FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **NEVADA**
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
Charlotte Crawford, Director

Date: June 30, 2000

Reporting Period: October 1, 1998 through September 30, 1999

Contact Person/Title: Dr. John Yacenda, Managing Chief, Nevada ✓ Check Up

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Date: August 11, 2000

Reporting Period: October 1, 1998 through September 30, 1999

Contact Person/Title: Dr. John Yacenda, Managing Chief, Nevada ✓ Check Up

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State Evaluation of Children's Health Insurance Plans

Table of Contents

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

Response: The State of Nevada is using Title XXI funds for a state stand-alone CHIP program. The program is for children ages 0 to 19, at or below 200 percent of federal poverty level and who are uninsured and ineligible for Medicaid. The Title XXI funds are used for health care benefits, and administrative costs which include marketing and outreach.

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

✓ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: Nevada ✓ Check Up_____

Date enrollment began (i.e., when children first became eligible to receive services): October 1, 1998

__ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

__ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):

_____

__ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

__ Other (specify) _____

Name of program:
_____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Response: N/A

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Response: N/A

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

Response: The major environmental factor that affects the CHIP program in Nevada is in access to health care for children who reside in the rural area of Nevada. Nevada has 17 counties of which 15 are considered rural areas. Approximately 27.5 percent of the children enrolled in Nevada ✓ Check Up reside in the rural areas. Under the CHIP program, children who reside in the rural areas access their care through Medicaid Fee-for-Service providers. There are a limited number of medical providers in the rural areas let alone an adequate number of Medicaid providers. Some rural communities have no doctor or as few as one doctor. Some families have to travel between 50-200 miles to the nearest doctor and/or hospital for treatment. This creates a dilemma for the families in trying to find an available medical provider and for the provider in trying to provide services to new patients.

How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Response: Initially, Nevada was going enroll all CHIP children in managed care, thus opting to offer the Bronze VI benefit plan of the largest commercial health maintenance organization (HMO), Health Plan of Nevada. In addition to paying a quarterly premium, the family would have to pay co-payments for dental, vision, and prescriptions. Because of the lack of contracted HMOs who were licensed and/or willing to provide services in the rural areas, the State opted to offer the Medicaid benefits package and to not charge co-payments. CHIP contracted with the Medicaid HMOs who provide health care services in two of the seventeen counties – Clark County and Washoe County (Reno/Sparks only). For the remaining fifteen counties, Medicaid Fee-for-Service (FFS) providers are used.

The HMOs are paid capitation rates that are 30 percent higher than Medicaid's because the HMOs have to provide services to children with special health care needs. Under Medicaid managed care, these children are covered under FFS. The Medicaid services that are carved out of the health benefits package include, dental, non-emergency transportation, Indian Health Services and Tribal Clinics, hospice, residential treatment centers, nursing home stays over 45 days, and school-based services are paid through a FFS wraparound. The following fee-for-service benefits require a prior authorization: orthodontia, more than 7 steel crowns in a single visit, and placement in a residential treatment center.

Because Nevada Medicaid had an asset/resource test, the Nevada ✓ Check Up was established as a separate application form. In order to meet the Title XXI Medicaid screening requirement for children who appear to be eligible, a copy of the Nevada ✓ Check Up application, along with copies of the wage stubs or federal income tax returns of the self employed, was sent to Medicaid for eligibility determination. Nevada ✓ Check Up enrollees are provisionally enrolled until a determination is made. If the child is found eligible for Medicaid, he is disenrolled from Nevada ✓ Check Up; if he is found ineligible due to excess income or resources, the child remains in Nevada ✓ Check Up. However, if the family fails to cooperate with Medicaid and is denied, the child is disenrolled from Nevada ✓ Check Up.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

No pre-existing programs were "State-only"

✓ One or more pre-existing programs were "State only"? Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

Response: The State Health Division had a dental program for children who were not

eligible for Medicaid and under 200 percent of poverty. With the implementation of the S-CHIP program, funding for the dental program was stopped, and the children are referred to S-CHIP.

The Health Division also has the Children's Special Health Care Services (CSHCS) program for children, ages 0 to 21, and under 200 percent of poverty. Children who are age 0 to 18, at or below 200 percent of poverty and are uninsured, are referred to CHIP for services. However, children who are ages 19 to 21 can continue to receive services through CSHCS. Once a special needs CHIP child turns 19, the child can apply to CSHCS and receive services until the age of 21.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

✓ Changes to the Medicaid program
___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
✓ Provision of continuous coverage (specify number of months 12)*1
___ Elimination of assets tests
✓ Elimination of face-to-face eligibility interviews
✓ Easing of documentation requirements

*1 Note: A State Plan Amendment was submitted to HCFA on April 24, 2000, to afford 12 months of continuous income eligibility.

Response: Initially the Nevada ✓ Check Up program required the family to submit copies of their two most recent pay stubs for each working adult in the household, along with a copy of their most current filed federal income tax return. A study was completed four months after implementing the program to find that 65 percent of the pending applications were due to failure to submit the income tax return. Submission of the income tax return was removed except for the self-employed. Removing this barrier, the pending applications decreased overall by 75%.

For the period of October 1, 1998 through September 30, 1999, the following Medicaid screening process was followed:

The Nevada ✓ Check Up program made copy of the CHIP application and copies of income documents, and sent them to the appropriate Welfare district office (by Zip

Code) for a Medicaid determination on CHIP children who appeared to be eligible for Medicaid. Nevada ✓ Check Up informed the family and gave them the option of "provisionally enrolling" their child in CHIP until a Medicaid determination was made. If the CHIP application is less than 60 days old, the eligibility worker accepted the CHIP application and sent a letter, along with a Rights and Obligation form, Voter Registration Form and Resource/Assets Forms, to complete and return.

Children who are denied or terminated from Medicaid due to excess income and resources are informed about the CHIP program in the Notice of Decision. Each month, CHIP is sent a list of these families who will be mailed a CHIP application. The goal is to enroll these children in CHIP.

✓ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

Response: The AFDC/TANF caseloads have dropped for the period of October 1, 1998 through September 30, 1999,enrollment versus an increase in Medicaid eligibles. The changes are as follows: (1)

	Oct 1998	**September 1999**
TANF	**36,039**	**33,477**
Medicaid Eligibles	**98,776**	**101,564**

(1) This information was obtained from the Welfare (WELF) Report.

The following are changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- ✓ (1) Health insurance premium rate increases
- ✓ (2) Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____
- ___ Changes in the delivery system
- ✓ (3) Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____
- ___ Development of new health care programs or services for targeted low-income children (specify)_____
- ✓ (4 Changes in the demographic or socioeconomic context

✓ (5) Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____

✓ 6) Changes in economic circumstances, such as unemployment rate (specify) _____

___ Other (specify) _____

___ Other (specify) _____

Response:

The following factors impacted the affordability and accessibility of private health insurance for Nevadans:

- According to the Nevada Division of Insurance, the health insurance premium rate increased an average of 10% in 1999, thus making health insurance less affordable.

- According to the Nevada Division of Insurance, the following regulatory changes took place in 1999: a) mental health parity; b) affording a woman 48 hours of hospitalization following delivery; c) contraception and hormonal therapy as covered benefits. Adding services increases the cost of health insurance, thus making health insurance less affordable

- According to the Nevada State Health Division, Bureau of Health Planning and Statistics, in September 1998, the state had 12 licensed HMOs, of which 9 provided services in the rural areas and. As of September 1999 and currently, there are 9 licensed HMOs, of which 7 provide services in the rural areas. None of the rural HMOs are contracted with CHIP. One of the contracted CHIP HMOs was purchased on July 1, 1999, by one of the other contracted HMOs, thus reducing the number of contracted CHIP HMOs from 4 to 3. The purchasing HMO assumed 400 CHIP members. The reduction in licensed HMOS adversely impacts accessibility as well as affordability of health insurance.

- According to the Department of Employment, Training and Rehabilitation, Employment Security Division, Bureau of Research and Analysis, the per capita income was $29,200 for 1998 and $30,351 for 1999. The 3.9% increase in per capita income did not negate the 10% increase in health insurance premiums.

- Nevada is one of the fastest growing states in the nation. According to the State Demographer's Office, in October 1998 there were approximately 1.4 million people; as of October 1999 there were approximately 1.9 million people. The growth is mainly in southern Nevada (Clark County). The fastest growing ethnic group in Nevada is the Hispanic population. in 1998 the Hispanic population was 1,826,646 Hispanic in 1999 it was 1,907,815. Population growth impacts affordability and accessibility to private health insurance.

- According to the Department of Employment, Training and Rehabilitation; and, Department Employment Security, Bureau of Research and Analysis, the unemployment rate in October 1998 was 4.1% and 4.6% in October 1999. The rise in unemployment adversely impacts accessibility and affordability to private health insurance.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

Response: Children ages 0 through 18, at or below 200 percent of the federal poverty level, and who are uninsured and ineligible for Medicaid.

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program***
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		Statewide	
Age		0 through 18	
Income (define countable income)		Gross income- Refer to Note to Table 3.1.1.	
Resources (including any standards relating to spend downs and disposition of resources)		N/A	

Residency requirements		6 months (1)	
Disability status		Ineligible if on SSI	
Table 3.1.1 continued	**Medicaid CHIP Expansion Program**	**State-designed CHIP Program**	**Other CHIP Program**
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))		State employees' children are ineligible. Not covered for 6 months prior to date of application except if terminated from Medicaid or looses health insurance due to no fault of employee.	
Other standards (identify and describe)			

(1) On April 24, 2000, Nevada submitted a State Plan Amendment to remove the 6 month s residency requirement.

Note to Table 3.1.1. The State of Nevada's definition of income and family size is as follows:

Income: Means adjusted gross income, as defined in the U.S. Internal Revenue Code, plus the following items: tax-free interest; the untaxed portion of pensions and or annuities; railroad retirement benefits; veterans' pensions and compensations; payments

received under the Social Security Act, including supplemental security income but excluding hospital and medical insurance benefits for the aged and disabled; public welfare payments, including shelter allowances; unemployment insurance benefits; all "loss of time" and disability insurance payments; disability payments under worker's compensation laws; alimony; support payments; allowances received by dependents of servicemen; the amount of recognized capital gain and losses excluded from adjusted gross income; life insurance proceeds in excess of $5,000; bequests and inheritances; cash gifts over $300 not between household members and such other kinds of cash flow into a household as the department specifies by regulation.

If it becomes necessary to request additional information or documentation to determine an applicant's eligibility, the most current household's income/information is utilized.

The household's annualized gross income/benefits (before deductions) may not exceed 200% of the federal poverty income guidelines published in the Federal Register each year.

Current income documentation is collected prior to the date of application, or application review, and annualized to determine the household's eligibility.

If the amount or date of receipt of income is unknown, that income is not counted. For example, if a participant has been awarded child support but has not received it for over 3 months, and the last time it was received it was for less than the amount ordered, the income is not counted until receipt of payment is reported or otherwise verified. Any income that can be anticipated with reasonable certainty is budgeted and counted for eligibility determination.

Income: (Not all-inclusive) Earned and Unearned:

- Employment Income/Tips (before any deductions), wages, salaries & commissions. Self-employment income (if the applicant has either income tax or FICA withheld from his earnings, he is an employee and not self-employed). Individuals are **not** considered self-employed if they work for a business or individual on a commission basis, e.g.: Avon, Tupperware, or any other commission employment. Their income is budgeted as earned income as an employee.)
- Social Security Income (Retirement, Survivors, and Disability Insurance) (Exempt RSDI or other income of SSI recipients), supplemental security income (SSI), disability income, Insurance or annuity payments, military allotments, and workers' compensation.
- Unemployment Compensation or Union Strike Benefits, Veterans' Benefits, and SIIS
- County Welfare, TANF/TANF-UP, Social Services, Indigent General Assistance (IGA), and church or charitable organization
- Alimony or any form of child support or family support not specifically mentioned

herein

- Training stipends and college or university scholarships, grants, fellowships, and assistantships
- Interest earnings from dividends, royalties, stocks, bonds, trusts, mutual funds, credit union accounts, and bank accounts
- Income from the sale of real property (non-owner occupied) land, rental income from property owned by the applicant or other household member
- Net income from farm employment
- Regular contributions from persons not living in the household, in kind income (count the value of work performed in exchange for benefits such as room, board, rent or other needs as earned income).
- Retirement Pensions
- Income from foster childcare, but not including any income a foster child earns.

EXCLUDED INCOME

- Food Stamps
- Housing Assistance (unless provided to the applicant by a private party)
- Utility Assistance (unless provided to the applicant by a private party)
- Loans (except when received or expected to be received on a regular basis over at least a six- month period)
- Payments made by others on behalf of the household member (except when received or expected to be received on a regular basis over at least a six-month period)
- Gambling winnings
- Wages held by an employer, without the employee's approval
- Nonrecurring lump sum, one-time payments
- Crime victim's payments
- Child's income, earned from employment
- Prizes or gifts. (However, if money is given on a regular basis over a period of six months or more, it is NOT considered a gift, but rather is counted as a voluntary support payment.)
- Tax Refunds
- Child support retained by Welfare
- Reimbursements or allowances to students or injured/physically challenged persons for specific education expenses such as travel or books. (However, funds provided for normal living expenses ARE counted as income.)
- Reimbursements, which do not exceed the expense incurred, or flat allowances for job or training-related expenses such as travel, per diem, uniforms, and medical or dependent care reimbursements.
- Capital gains (unique one-time events)
- Any assets drawn down as withdrawals from a bank
- Lump sum payments from the sale of property, a house, a car; lump sum inheritance, a one-time insurance payment or compensation for an injury
- Payments received under Title II of the Uniform Relocation Assistance and Real

Property Acquisition Policies Act of 1970, including:

a) Payments to persons displaced as a result of the acquisition of real property
b) Relocation payments to a displaced homeowner toward the purchase of a replacement dwelling

- Per capita payments made to any Indian Tribe in satisfaction of a judgment of the Indian Claims Commission or the Court of Claims through the Department of the Interior (as either the distributor or reviewer of the judgment)
- Money paid from one household member to another member of the same household, unless the income is from a roomer/boarder situation, which is then classified and counted as rental income.
- All funds received from the Federal Emergency Management Administration (FEMA) for disaster relief or comparable assistance provided by states, local governments or private disaster assistance organization(s) pursuant to Section 312 of the Stafford Act.
- Any portion of military pay which is deducted from the gross amount to fund educational programs under the GI Bill
- Any funds received through Title V of the Older American Act (AARP administers one such program called Senior Citizens Service Employment Program).
- Any payment made from the Agent Orange Settlement fund or any other fund established in connection with settling liability claims concerning Agent Orange.
- Payments pursuant to the Radiation Exposure Compensation Act.
- Reparation payments issued to Japanese Internees pursuant to Public Law 101-201.
- Payments to victims of Nazi persecution.
- Payments from ACTION programs including:
    c) VISTA
    d) Foster Grandparent Program
    e) Service Corp of Retired Executives (SCORE)
    f) Active Corps of Executive (ACE)
    g) Community Service Employment Program
    h) Senior Companion Program
    i) Retired Senior Volunteer Program
    j) Mini Grant Program
- The portion of student assistance, which is issued for specific education expenses (not including normal living expenses) under programs administered by the Commissioner of Education as follows:
    k) Basic Education Opportunity Grants Programs (BEOG/PELL).
    l) Supplemental Educational Opportunity Grant (SEOG).
    m) National Direct Student Loans (NDSL/Perkins Loans).
    n) Stafford Loans (SL/GSL) Loans to students guaranteed by the federal government.
    o) Nevada State Incentive Grant (NSIG) or State Student Incentive Grant

(SSIG).

- Foster Care payments received for clothing and food allowances.
- Reserve money in the bank (only interest or dividends of money).
- Independent Living Payments.
- As of January 2000, income paid by the Census Bureau for temporary employment related to the Census 2000 activities.

Family Size: For the CHIP program, the family may include the applicant (whose is deemed head of household), spouse, children, stepchildren, adopted children, grandchildren, step-grandchildren, parents, step-parents, parents-in-law, grandparents, brothers, sisters, step-brothers, step-sisters, sisters-in-law, brothers-in-law, sons-in-law, and/or daughters-in-law living with the child(ren) who are enrolling. Also, a boyfriend or girlfriend living with the applicant may be included as an other adult in the household. You may count, as listed above, any person(s) who receives at least 50% support from the family's wage earner(s). You may also count, as a family member, any related person(s) who appears as a dependent on the family's income tax return or any children who live in a household that has legal custody or guardianship over them.

Note: The above definitions are incorporated into Addendum to Tables 3.1.1.3. and 3.1.1.4.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and S-CHIP programs and included in the NASHP S-CHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid S-CHIP expansion and State-designed S-CHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here ? and indicate whom you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	____	Gross	✓	Net	____	Both
Title XXI Medicaid S-CHIP Expansion	____	Gross	____	Net	____	Both
Title XXI State-Designed S-CHIP Program	✓	Gross	____	Net	____	Both
Other S-CHIP program_____	____	Gross	____	Net	____	Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	____	% of FPL for children under age	_____
	____	% of FPL for children aged _____	_____
	____	% of FPL for children aged _____	_____
Title XXI Medicaid S-CHIP Expansion	____	% of FPL for children aged _____	_____
	____	% of FPL for children aged _____	_____
	____	% of FPL for children aged _____	_____
Title XXI State- S-CHIP Program through 18	200	% of FPL for children aged	0
	____	% of FPL for children aged _____	_____

____% of FPL for children aged _____

_____

Other S-CHIP program_____ ____% of FPL for children aged

_____

____% of FPL for children aged _____

_____

____% of FPL for children aged _____

_____

3.1.1.3 Complete Table 3.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3				
Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid S-CHIP Expansion	Title XXI State-designed S-CHIP Program	Other S-CHIP Program*
Child, siblings, and legally responsible adults living in the household			Y	
All relatives living in the household			D	
All individuals living in the household			D	
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid S-CHIP Expansion	Title XXI State-designed S-CHIP Program	Other S-CHIP Program*
Earnings Earnings of dependent children			C NC	
Earnings of students			C	
Earnings from job placement programs			NC	
Earnings from community service programs under Title I of the			NC	

National and Community Service Act of 1990 (e.g., Serve America)				
Table 3.1.1.4				
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)			NC	
Education Related Income Income from college work-study programs			C	
Assistance from programs administered by the Department of Education			NC	
Education loans and awards			C	
Other Income Earned income tax credit (EITC)			NC	
Alimony payments received			C	
Child support payments received			C	
Roomer/boarder income			C	
Income from individual development accounts			C	
Gifts			NC	
In-kind income			C	
Program Benefits Welfare cash benefits (TANF)			C	
Supplemental Security Income (SSI) cash benefits			C	
Social Security cash benefits			C	
Housing subsidies			NC	
Foster care cash benefits			C	
Adoption assistance cash benefits			NC	
Veterans benefits			C	

Emergency or disaster relief benefits			NC	
Low income energy assistance payments			NC	
Table 3.1.1.4				
Native American tribal benefits			NC	
Other Types of Income (specify)				

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)____Yes __✓__ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5				
Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid S-CHIP Expansion	Title XXI State-designed S-CHIP Program	Other S-CHIP Program*
Earnings	$	$	$ NA	$
Self-employment expenses	$	$	$ Per federal income tax return	$
Alimony payments Received	$	$	$ NA	$
Alimony payments Paid	$	$	$ NA	$
Child support payments Received	$	$	$ NA	$
Child support payments Paid	$	$	$ NA	$

Child care expenses	$	$	$ NA	$
Medical care expenses	$	$	$ NA	$

Table 3.1.1.5				
Gifts	$	$	$ NA	$
Other types of disregards/deductions (specify)	$	$	$ NA	$

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups ____No ____Yes (complete column A in 3.1.1.7)

Title XXI S-CHIP Expansion program ____No ____Yes (complete column B in 3.1.1.7)

Title XXI State-Designed S-CHIP program ✓ No ____Yes (complete column C in 3.1.1.7)

Other S-CHIP program_____ ____No ____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Response: Refer to Table 3.1.1.7.

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid S-CHIP Expansion (B)	Title XXI State-designed S-CHIP Program (C)	Other S-CHIP Program (D)
Countable or allowable level of asset/resource test	$	$	$ NA	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*			NA	
What is the value of the disregard for vehicles?	$	$	$ NA	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*			NA	

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes ✓ No

Response: On March 9, 2000, Nevada submitted a State Plan Amendment to exempt from countable income, all wages paid by the Census Bureau for temporary employment related to Census 2000 activities. On April 24, 2000, Nevada submitted a State Plan Amendment to change the following: (1) process redeterminations on a "rolling basis". That is, "A child is eligible until the annual eligibility redetermination date, no later than one year from the most recent date of enrollment"; (2) waiving the 6 month residency requirement; (3) waiving cost sharing for American Indians and Native Alaskans who are members of Federally recognized Tribes.

The reasons for the changes are as follows: (1) A rolling redetermination affords a child 12 months of income eligibility (refer to 3.1.3); (2) even though only 18 children were denied enrollment because of not meeting the 6-month residency requirement as of the date of their CHIP application the 6 month residency requirement was considered an application barrier; and (3) removing cost sharing for American Indians and Native Alaskans was mandated by Title XXI regulations.

3.1.2. How often is eligibility redetermined?

Response: Refer to Table 3.1.2.

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months			
Other (annual eligibility redetermination date, October 1, of each year)		✓	

3.1.3. Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

__✓ Yes ? Which program(s)? Nevada ✓ Check Up

For how long? Up to 12 months

___ No

Response: The family can be income eligible for up to 12 months depending on when they enrolled. Currently, because of the annual redetermination process, if they enrolled after October 1st they will have less than 12 months of coverage since the program year is October 1st through September 30th. This process will change when the State Plan Amendment is approved to allow "rolling redeterminations"; the child will be redetermined within 12 months of his anniversary date (refer to Section 3.1.1.8).

The program is in the process of drafting a fraud policy to cover situations when an applicant misrepresented their income (not reported all of their income) at the time of application and/or redetermination, and the income is found to be above 200 percent of poverty, the children could be disenrolled. The program is in the process of entering into a Memorandum of Understanding (MOU) with the Employment Division to utilize their database to verify income. However, this source can only be used on those applicant's who provide their Social Security Number (SSN). Because Nevada's CHIP program is not an expanded Medicaid program, the applicant does not have to report the SSN of any member of the household.

3.1.4 Does the CHIP program provide retroactive eligibility?

_✓_ Yes ? Which program(s)? Nevada ✓ Check Up

How many months look-back? Month of infant's birth.

___ No

Response: When an enrolled child or a mother who has children enrolled gives birth, the newborn is enrolled effective the month of birth. The only exceptions are if the mother failed to inform us of her pregnancy prior to birth or if the adult mother has health insurance which would cover the baby for the first 30 days of life. When the reporting of the birth is after administrative cut-off or after the month of birth, the baby is enrolled retroactively.

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ? Which program(s)?_____

Which populations?_____

Who determines? _____

_✓_ No

Response: During the drafting of the State Plan, Nevada considered presumptive eligibility. This was discussed at public hearings, which were conducted before the Legislative Committee on Health Care regarding the fiscal impact of having presumptive eligibility. Nevada opted not to have presumptive eligibility for its CHIP program.

3.1.6 Do your Medicaid program and CHIP program have a joint application?

___ Yes? Is the joint application used to determine eligibility for other State programs? If yes, specify.

_✓_ No

Response: Nevada Medicaid has an income and asset test, so CHIP did not attempt to design a joint application. When a CHIP applicant appears to be income eligible for Medicaid and answers on their application that their resources do not exceed the Medicaid limit, a copy of the CHIP application along with the income verification documents are sent to the appropriate Welfare district office (by zip code) for a full Medicaid determination. The eligibility worker will then contact the family and ask them to provide additional information. If the family fails to cooperate, they will be denied Medicaid and CHIP as required under Title XXI regulations.

As of January 2000, the Medicaid referral process has changed. To streamline the process, Medicaid eligibility worker is stationed in Nevada ✓ Check Up 3 days a week and the face-to-face interview is waived.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Response: The eligibility process for Nevada ✓ Check Up entails three phases. The first phase is processing the application; the second phase is the determination (approve, pend, or deny); and, the third phase is enrollment. This process results in both strengths and weaknesses. The major strengths are as follows:

Application Process:

The application packet provides information regarding eligibility; income and premium charts, explains the difference between Medicaid and Nevada ✓ Check Up, covered benefits, and how to access services. The application is one page two-sides, printed in English or Spanish. Eligibility is based on the family's gross annual income. The application is also available on the program's web page. To verify the family's income, the applicant only needs to provide copies of the two most current pay stubs of each working adult in the household. If the applicant is self-employed, copy of the most recently filed federal income tax return is required. If a child is not a U.S. citizen, a copy of an alien registration card is required. The application and documents can be mailed or faxed, and a face-to-face interview is not required.

Application assistance is provided by calling a bilingual toll free line. Bilingual staff is available to assist an applicant.

Determination Process:

The average period of time that elapses from the time an application is received in the office to the time an eligibility determination is made is 15 working days if the applicant has completed the application correctly and submitted the required income and/or citizenship documentation. If the application is incomplete the family is sent a Notice to submit the information within 30 days; thus it may take a total of 45 days to make a determination.

Enrollment Process:

Approved applicants are sent an enrollment packet which includes the amount of the quarterly premium, information on health plans if they reside in the counties of Washoe or Clark, along with a managed care brochure. If the family does not reside in the counties of Washoe or Clark, their enrollment packet includes information on how to access their care (Refer to Attachment C.) under fee-for-service as well as the amount of the quarterly premium. The enrollment form and premium payment must be returned within 30 days to enroll their children the first day of the next administrative month.

The major weaknesses are the following:

Application Process:

The major weakness of the program is requiring the family to provide the income documentation. Approximately 60 percent of new applications are placed in "pending" due to lack of supplying the required income documentation. This extends the processing time to at least 45 days.

Determination Process:

Of the 6,074 children who were denied, 1,472 or 24.2 percent of the "pending" applications result in denials due to "lack of cooperation," even though they are sent a notice giving them 30 days to provide the documentation.

Enrollment Process:

Effective date of health coverage under Nevada ✓ Check Up is the first day of the administrative month following receipt of the enrollment form and premium payment. Applicants who are approved are sent an enrollment form to complete that also includes the amount of the quarterly premium. The family has to return both the enrollment form and premium payment within 60 days before their children are enrolled. Each program month has an administrative cut-off date for enrollment. If the family submits the enrollment form and premium payment prior to the cut-off date, the child is enrolled the first day of the following month. However, if the enrollment form and premium payment is received after cut-off, the children are not enrolled until the first day of the second month, resulting in the children not having health insurance for two months after receipt of the enrollment form and premium.

Approximately 525 households, or 8 percent of the applications, approved did not respond to the enrollment packet (complete and/or return the enrollment form and/or premium payment.) This resulted in approximately 1,100 eligible children (2.1 children per household) not being enrolled in Nevada ✓ Check Up.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Response: The redetermination process differs from the initial eligibility process by the following:

1. A computer printout is generated which contains the family history as supplied on the initial application. If there are changes, the head of household is to annotate the changes on the form, sign it and attach the required income documents. If there are no changes, the head of household must sign the form and attach the required income documents. The material is to be mailed in the program's self-addressed envelope.

Enrollees are sent several friendly reminder notices encouraging them to respond to the redetermination request. If they do not respond, they are sent a "Notice of Termination" informing them of the termination date and their rights to file an appeal.

Strength:

- The redetermination form is simple for the family who needs to review and annotate changes, if any, on the form;
- Submit copies of recent pay stubs or recent file income tax return; and,
- Sign and return the form in the program's stamped self-addressed envelope

Weakness:

- All enrolled children are re-determined at the same time annually;
- The child's anniversary enrollment date could be less than 12 months at the time of the annual redetermination,
- Deprives a number of children from being enrolled for a full year;
- Creates confusion for those families who enrolled within 6 months of the annual redetermination; and,
- Results in an overwhelming caseload for the eligibility workers and requires the program to hire contract staff;

3.2 What benefits do children receive and how is the delivery system structured?

(Section 2108(b)(1)(B)(vi))

Response: Under Nevada ✓ Check Up, enrolled children receive the Medicaid health benefits package. Children who reside in southern Nevada (Clark County) and in northern Nevada (Washoe County, Reno/Sparks only) access their care through contracted health plans. Children who reside in rural Nevada access their care through Medicaid fee-for-service providers.

The health plans are required to provide, at a minimum, the same level of services as provided under Medicaid. The health plans are encouraged to offer additional preventive or cost effective services to members if the services do not increase the cost to the state.

Certain services are carved out of the health plan benefits package and are paid through a fee-for-service (FFS) wraparound. These services include dental, non-emergency transportation, residential treatment centers, hospice, Indian Health Services and Tribal Clinics, school-based services, and nursing home stays over 45 days.

The following fee-for-service benefits require a prior authorization: orthodontia, more than 7 steel crowns in a single visit, and placement in a residential treatment center.

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Response: Refer to Table 3.2.1.

Table 3.2.1 CHIP Program Type **- State Designed**			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	✓	No	
Emergency hospital services	✓	No	
Outpatient hospital services	✓	No	
Physician services	✓	No	
Clinic services	✓	No	
Prescription drugs	✓	No	
Over-the-counter medications	✓	No	
Outpatient laboratory and radiology services	✓	No	
Prenatal care	✓	No	
Family planning services	✓	No	
Inpatient mental health services	✓	No	Prior authorization is required for Residential Treatment Centers placements and extended stays.
Outpatient mental health services	✓	No	
Inpatient substance abuse treatment services	✓	No	
Residential substance abuse treatment services	✓	No	
Outpatient substance abuse treatment services	✓	No	
Durable medical equipment	✓	No	
Disposable medical supplies	✓	No	
Preventive dental services	✓	No	

Restorative dental services	✓	No	Orthodontics and more than seven steel crowns in one visit require prior authorization.
Hearing screening	✓	No	
Hearing aids	✓	No	
Vision screening	✓	No	
Corrective lenses (including eyeglasses)	✓	No	
Developmental assessment	✓	No	
Immunizations	✓	No	
Well-baby visits	✓	No	
Well-child visits	✓	No	
Physical therapy	✓	No	
Speech therapy	✓	No	
Occupational therapy	✓	No	
Physical rehabilitation services	✓	No	
Pediatric services	✓	No	
Chiropractic services	✓	No	
Medical transportation	✓	No	

Home health services	✓	No	
Nursing facility	✓	No	
ICF/MR	✓	No	
Hospice care	✓	No	
Private duty nursing	✓	No	
Personal care services	✓	No	
Habilitative services	✓	No	
Case management/Care coordination	✓	No	
Non-emergency transportation	✓	No	
Interpreter services	✓	No	
Other (Specify)		No	
Other (Specify)		No	
Other (Specify)		No	

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Response: The health benefit package for CHIP is the Medicaid benefit package. However, under the CHIP program there are no co-payments for covered health care benefits. The child is entitled to the following preventive services: Healthy Kids Screening, immunizations, preventive dental, and family planning. The following enabling services are offered to CHIP enrollees: non-emergency transportation, interpretative services, individual needs assessment, home visits, community outreach, and translation of written materials.

Children who have pre-existing special health needs are not denied enrollment or services. They like the other enrollees are entitled to special needs assessment for mental health services. These early childhood intervention services can be provided by the contracted health plans through their provider network, Division of Health, Special Children's Clinic (SCC); Division of Child and Family Services (DCFS) through their Happy or First Step Programs. If a child needs residential treatment center (RTC) services, a prior authorization is required from the programs contracted peer review organization (PRO). RTC services are carved out of the health plan benefit package and are paid under fee-for-service.

If a child is enrolled in a health plan, the plan must coordinate with the following agencies and /or providers for their services:

- School-Based Child Health Services;
- Indian Health Services and Tribal Clinics;
- Certified Nurse Midwife Services if not in their provider network;
- Special Supplemental Food Program for Women, Infants and Children.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Response: Refer to Table 3.2.3.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCO's)			
Statewide?	___ Yes ___ No	___ Yes ✓ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	✓ Yes ___ No	___ Yes ___ No
Number of MCO's		3	
B. Primary care case management (PCCM) program		No	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)		N/A	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		Dental, non-emergency transportation, hospice, Indian Health Services and Tribal Clinics, over 45 days nursing care, Residential Treatment Centers, and school based services.	
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

3.3 How much does CHIP cost families?

Response: The only cost sharing under Nevada ✓Check Up is the quarterly premium payment. The annual costs range from $40 to $200 per family (not per child) based on their poverty level. (Refer to

3.3.2.)

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_✓_ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ _
Premiums		✓	
Enrollment fee			
Deductibles			
Coinsurance/copayments			
Other (specify) _____			

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lockout) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Response: A quarterly premium is charged per family (not per child) and is based on gross income and federal poverty level (100-150% , 151-175%, and 176-200%). The quarterly premium is due at the time of initial enrollment. If the children are enrolled in the third month of a quarter the premium is applied to the next premium quarter. Once enrolled, the premium is due on the first day of each quarter (January 1, April 1, July 1, and October 1). The premiums are as follows:

Family of 4	Quarter Premiums	Total Annual Premiums	Family of 3	Quarterly Premiums	Total Annual Premiums
Up to $16,950	$10	$40	*Up to $20,820	$10	$40
$16,591 – 19,355	$25	$100	$20,821 – 24,290	$25	$100
$19,356 – 22,120	$50	$200	$24,291 – 27,760	$50	$200

Family of 4	Quarterly Premiums	Total Annual Premiums	Family of 5	Quarterly Premiums	Total Annual Premiums
*Up to $25,050	$10	$40	*Up to $29,280	$10	$40
$25,051 – 29,225	$25	$100	$29,281 – 34,160	$25	$100
$29,226 – 33,400	$50	$200	$34,161 – 39,040	#50	$200

*Some families with very low income may have the quarterly premiums waived.

Families are informed at the time of enrollment of the timing and amount of premiums, and a reminder notice is sent approximately 3 weeks prior to the due date. If the family fails to submit premium payment by the 10th day of the month the premium is due, the health plan will be sent a listing of families who have not paid the quarterly premium. The health plan will be encouraged to contact each family by letter or phone. If a family is not enrolled in a health plan, the program will send the family a reminder notice. If payment is not received by the 45th day of the quarter, the family will be sent a notice of disenrollment to be effective the first day of the next administrative month. Thus, if the family does not pay the premium, the children have received two months of free coverage.

If the child reapplies within the enrollment year and is found eligible, prior to onset of coverage, the family must pay the delinquent premium as well as the current premium. There is no lockout period before a family may re-enroll.

As of May 2000, with respect to premium collections, an evaluation is being done regarding the use of a commercial bank lock box service . This service is very efficient and would potentially free up staff to perform other accounting functions and accommodate additional enrollment growth. To assist families with the premium payment, an evaluation is being done regarding private donations and sponsorships.

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
✓ Family
✓ Absent parent
___ Private donations/sponsorship
✓ Other (specify) - Several of the Tribal Councils for Native Americans. This will be waived under the proposed State Plan Amendment

3.3.4 If an enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

Response: Not applicable

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

Response: Not applicable

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

Response: A quarterly premium is charged per family based on gross income and federal poverty level as follows: 100-150% of poverty = $10, 151-175% of poverty = $25, and 176-200% of poverty = $50. Families are informed at the time of enrollment of the payment dates and amount of premium. The premium payments are minimal (do not come close to the 5 percent cap); however, they are informed that there are no other out-of-pocket costs. A premium reminder notice is sent approximately 3 weeks prior to the due date. If the family fails to pay the premium by the 10th day of the month the premium is due, they are sent a reminder notice. If they haven't paid the premium by the 45th day of the quarter, they are sent a disenrollment notice.

3.3.7 How is your CHIP program monitoring that annual aggregate cost sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
_✓_ Other (specify) Enrollment database

Response: The only out of pocket expense that a family has under Nevada ✓ Check Up is the premium payment. The family premium payments are very minimal - $10, $25 or $50 based on the family's gross annual income (federal poverty level). The premium is per household rather than by child. As such, the annual out-of-pocket expense comes nowhere close to the 5 percent cap. In addition, the family is informed at the time of application and enrollment that there are no co-payments. Providers have been informed through a provider letter and through provider workshops that there are no co-payments for children covered under Nevada ✓ Check Up.

Because of the low family premium payment, no formal program monitoring is required regarding the aggregate cost sharing per family; however, the premium data is available in the program's enrollment database. If a family reports that they were charged for a covered service by a Medicaid provider and reports the problem, the provider is contacted by the program and instructed to refund the family and submit his bill to the program's fiscal agent.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

Response: N/A – refer to response in 3.3.6.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Response: During the annual redetermination process a member satisfaction survey was sent to 3,080 families; 2,090 families completed and returned the survey. Question 6 of the survey addressed the premium payment. The question and response are as follows:

Question: What is the amount of your quarterly premium and is the amount fair for the services received?"

Response: Statewide, 1,950, or 93.3% indicated it was fair; 5.5% did not answer the questions and 1.1% felt is it was unfair. The statewide mean amount of the premium was $16.55; and by county - Clark County $16.29, Washoe County $17.64, and Rural Nevada $16.16.

3.4 How do you reach and inform potential enrollees?

Response: To reach and inform potential enrollees the following statewide marketing and outreach collaboration efforts were completed between March 1998 and September 30, 1999:

<u>Statewide Collaboration</u>: What is Nevada Doing?

Department of Education Free/Reduced Price Meal, Lunch Program	Collaborating with the Department of Education's Free/Reduced Price Meal, Lunch Program to create, attach and distribute a waiver to release the name and address of those families who are interested in receiving a Nevada ✓ Check Up packet. **Outcome:** Over 267,000 waivers were attached to the Free/Reduced Price Meal, Lunch Program. Over 14,000 waivers requesting applications were sent to Nevada Check Up from families interested in the program. Of the 14,000 requests, over 3,000 were enrolled through this effort.
Department of Education School Nurses	Partnering with the Nevada State School Nurses Association to conduct awareness workshops in identifying, facilitating and enrolling uninsured children in Nevada's schools. **Outcome:** The Nevada ✓ Check Up Program poster was distributed statewide to 465 schools. Attached to the poster are 25, self-addressed, postage-paid postcards that can be torn off and sent in requesting an application. Over 1,435 postcards were returned.
Department of Human Resources Welfare Department	Establishing onsite Medicaid eligibility staff to screen families who may be eligible for Medicaid, instead of referring them to the nearest Welfare Office. Removing the face-to-face interview for families who apply for the Children's Health Assurance Program (CHAP) at the Welfare Office. Obtaining reports of those children who are denied for excess income and age and send information to those families. **Outcome:** A total of 1,604 children were Medicaid referrals of which 983 children opted to provisionally enroll in Nevada ✓ Check Up.

Department of Human Resources, Women, Infants and Children (WIC) Program	Partnering with the Women Infants & Children (WIC) program in creating a referral form for those families who apply with WIC and do not have health insurance. WIC will send the completed form to Nevada ✓ Check Up. **Outcome:** Over 145 WIC food vendors distributed Nevada ✓ Check Up information to their clients. The referral process has captured 498 families to date. A total of 1,207 children have applied of which 1,039 have been enrolled.
Department of Human Resources, Children's Special Health Care Needs Program	Partnering with the Children with Special Health Care Needs Program. **Outcome:** Over 700 referrals have been received.
Department of Human Resources, Baby-Your-Baby Program	Educating, coordinating and collaborating with the Baby-Your-Baby program in identifying uninsured children who may qualify for the Nevada ✓ Check Up Program. **Outcome:** The referral process captured 87 families. A total of 182 children applied of which 90 have been enrolled.
Department of Human Resources, Family To Family Connection	Educating, coordinating and collaborating with the Family-to-Family Connection in identifying uninsured children who may qualify for the Nevada ✓ Check Up Program. **Outcome:** Referral process has captured 210 families. A total of 492 children applied of which 212 have been enrolled.
Department of Human Resources, Family Resource Centers	Educating, coordinating and collaborating with the Family Resource Centers program in identifying uninsured children who may qualify for the Nevada ✓ Check Up Program. **Outcome:** Referral process has captured 255 families.
Department of Human Resources, Community Health Nursing	Educating, coordinating and collaborating with community health nurses to identify uninsured children who may qualify for the Nevada ✓ Check Up Program. **Outcome:** A total of 913 children have applied of which 382 have been enrolled.
Department of Human Resources, Child Care Licensing Bureau and all county and city child care locations	Obtaining addresses and mailing Nevada ✓ Check Up informational packets to all licensed day care centers in the State of Nevada. Outreach efforts reached over 10,000 children. **Outcome:** Creating greater awareness of the Nevada ✓ Check Up program among those targeted families with small children who utilize child care facilities by educating child care owners/directors of the benefits of the program and distributing poster in every child care center in the state.
Department of Employment, Training & Rehabilitation Employment Security Division	Coordinating and distributing over 32,000 informational flyers in unemployment checks to families the month of October 1998. **Outcome:** Creating greater awareness of the Nevada ✓ Check Up program among the targeted groups of low-income families who may qualify for the program.

Bureau of Disability Adjudication	Coordinating and distributing informational packets to families that do not qualify for Social Security benefits. Over 2,000 families have received information. **Outcome:** Providing a referral source for the Nevada ✓ Check Up program to target those children who have been denied Social Security benefits and most likely will qualify for Nevada ✓ Check Up program.
Boys and Girls Club's of America	Coordinating and distributing over 5,000 informational packets to families that use Boys and Girls Club's of America. **Outcome:** Creating greater awareness of the Nevada ✓ Check Up program among the targeted group of families who utilize these facilities.
Public and State Housing Programs	Coordinating with Reno Housing Authority, Las Vegas Housing Authority, Housing Authority of North Las Vegas, Housing Authority of Clark County, Carson City rural Housing Division and Housing division distributed information to over 10,000 families. **Outcome:** Creating greater awareness of the Nevada ✓ Check Up program among the targeted group of families who utilizes these services.
Tribal Organizations	Partnering with all tribal organizations. Attending health fairs, specialty meetings and events, conducting presentations and providing information for publications and newsletters. **Outcome:** A total of 449 Native American children applied of which 160 have been enrolled.
Multiple Organizations (To name a few) County and community social services agencies, public hospitals, medical providers, rural clinics county public health departments, FQHC's, Legal Aid Offices, United Way, IHS, Hispanic Services, Children's Cabinet, Grandparents Raising Grandchildren, Head Start, African-American community organizations, faith organizations, and many, many more.	Educating, coordinating and collaborating with multiple organizations to identify uninsured children who may qualify for the Nevada ✓ Check Up Program. Attending health fairs, specialty meetings, and events; conducting presentations and providing information for publications and newsletters. **Outcome:** Physician referrals include 1,204 who have applied of which 609 have been enrolled. Social service referrals include 1,049 children who have applied of which 446 have been enrolled.
Temporary Employment Agencies	Distributing over 2,000 informational packets to Temporary agencies throughout the state of Nevada. **Outcome:** Creating greater awareness of the Nevada ✓ Check Up program among those who utilizes temporary employment services.

Major Businesses	Establishing partnerships with large businesses that employ the majority of low-income families, i.e., casino's, manufacturer's, utilities, and fast-food establishments for the purpose of educating their employees about the availability of low-cost health insurance for their dependents. Distributed over 2,000 letters informing Human Resource Managers about the Nevada ✓ Check Up program. Establishing partnerships with local Chamber of Commerce to assist in distributing program information to private and public entities. **Outcome:** Included "how did you hear about the Nevada ✓ Check Up program" as "Other" a total of 2,392 children have applied of which 1,116 have been enrolled.
Covering Kids Coalition	Partnering with the Covering Kids Coalition, the recipients of a grant from Robert Wood Johnson Foundation to identify and enroll uninsured children throughout the State of Nevada. **Outcome:** Outreach efforts have referred 52 children of which 17 have been enrolled.
Innovative Outreach	Families can download an application both in English and Spanish from the internet address of www.nevadacheckup.com Model Dairy advertised the Nevada ✓ Check Up program on milk cartons two weeks in November of 1998. Outreach effort reached over 1.2 million families. Linking to multiple web-sites so families can retrieve information about the Nevada ✓ Check Up program. Creating a personal bond with Nevada ✓ Check Up parents by establishing a "Children's Hall of Fame". Parents send in photos of their children. Anchoring to reputable local community entities and boards to assist in establishing partnerships with small businesses to promote the Nevada ✓ Check Up Program. Conducting PSA's statewide in the summer of 1998 and 1999.

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (?=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Response: Refer to Table 3.4.1.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers			✓	4		
Direct mail by State/enrollment broker/administrative contractor			✓	3		
Education sessions			✓	4		
Home visits by State/enrollment broker/administrative contractor						
Hotline			✓	5		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake			✓	3		
Public Service Announcements			✓	5		
Public access cable TV			✓	5		
Public transportation ads						
Radio/newspaper/TV advertisement and PSA's			✓	4		

Signs/posters			✓	4		
State/broker initiated phone calls						
Other (specify) - Milk Cartons			✓	2		
Other (specify) - Schools Other (specify) – Sister Agencies Other (specify) – Non-profit entities			✓ ✓ ✓	5 4 3		

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (?=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Response: Refer to Table 3.4.2.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters			✓	2		
Community sponsored events			✓	2		
Beneficiary's home						
Day care centers			✓	3		
Faith communities			✓	2		
Fast food restaurants						
Grocery stores						
Homeless shelters			✓	2		
Job training centers			✓	2		
Laundromats			✓	3		
Libraries			✓	2		
Local/community health centers			✓	3		
Point of service/provider locations			✓	3		
Public meetings/health fairs			✓	3		
Public housing			✓	3		
Refugee resettlement programs						
Schools/adult education sites			✓	5		

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Senior centers						
Social service agency			✓	4		
Workplace			✓	3		
Other (specify)						
Other (specify)						

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Response: The methods and indicators used to assess outreach effectiveness were the number of applications received to the number of actual enrolled. See outcomes referenced in section 3.4.

Additionally, the Nevada ✓ Check Up application includes a question stating, **"How did you hear about Nevada ✓ Check Up?" The responses include: Media, Friend/Relative, School, Resource Center, Doctor, Social Services, WIC, Health Department, Baby-Your-Baby, Family-to-Family, Welfare Department, Internet, and Other.** The applicant's response is entered into the application database. The results of the applications submitted for the period of October 1, 1998, through September 30, 1999, are as follows:

Source	Percent
Media	10%
WIC	4%
Relative/Friend	15%
Health Department	3%
Baby-Your-Baby	1%
School	33%
Family to Family	2%
Family Resource Center	2%
Doctor	6%
Social Services	5%
Other	9%
Welfare Department	10%
Robert Wood Johnson	0%

3.4.4. What communication approaches are being used to reach families of varying ethnic backgrounds?

Response: The program's written material is provided in both English and Spanish. The following communication approaches were used during the reporting period:

Hispanic Community:

- Bilingual staff employed to assist in marketing the program to the Hispanic community;
- Bilingual staff conducted interviews on Hispanic television and radio stations;
- Partnered with local Hispanic organizations to conduct outreach to the local Hispanic community.

Native American Community:

- Formation of a Native American Advisory Committee that meets six times a year to monitor progress and accountability of the Nevada ✓ Check Up program;

- Utilization of the Native American Advisory Committee to disseminate information to the appropriate target groups;
- Inter-Tribal Council of Nevada provides the Nevada ✓ Check Up program the opportunity to exchange and disseminate information between the State of Nevada and the different Tribal Councils.

Various community based organizations as well as local advisory boards have assisted us in reaching the Asian, African American and other ethnic populations.

3.4.5. Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Response: As the result of the culturally sensitive marketing and outreach efforts by the staff, various ethnic groups have applied and enrolled in the Nevada ✓ Check Up. In comparison (by percentage) to the state demographics, children of the following ethnicity have applied and are enrolled:

Ethnicity:	In the State (1)	Applied(2)	Enrolled(2)
Native Americans	**2.9%**	**2.9%**	**2.2%**
African Americans	**7.2%**	**8.8%**	**8.0%**
Asians	**3.3%**	**3.6%**	**3.3%**
Hispanics	**12.3%**	**29.3%**	**28.4%**

(1) State percentages are for 1999 as prepared by the Nevada State Demographer.
(2) Program percentages are based on the September 30, 1999, program reports.

The most successful outreach method for all populations has been the schools. The following chart reflects the referral source compared to ethnic group:

Referral Source	Native American	African American	Asian	Hispanic	White	Other	Total
Baby Your Baby	1	7	7	40	44	24	123
Covering Kids (RWJ)	0	0	0	4	13	0	17
Doctor	33	41	21	272	308	103	778
Family To Family	9	25	3	188	78	63	366
Friend or Relative	47	174	57	570	1118	207	2173
Head Start		4	2	15	7	9	37
Health Dept.	82	42	12	175	215	71	597
Media	39	182	71	341	863	156	1652
Other	84	156	54	520	694	188	1706
Resource Center	14	63	14	89	144	45	369
School	91	446	265	1655	2873	464	5784
Social Services	21	68	20	249	300	89	747
Welfare	32	157	37	384	587	175	1372

WIC	12	37	19	382	142	70	662
Total	465	1402	582	4884	7386	1664	16383

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, and School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Response: Refer to Table 3.5.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) WIC	Other (specify) School Lunch
Administration	✓			
Outreach	✓	✓	✓	✓
Eligibility determination	✓			
Service delivery	✓			
Procurement				
Contracting	✓			
Data collection	✓			
Quality assurance	✓			
Other (specify)				
Other (specify)				

**Note: This column is not applicable for States with a Medicaid CHIP expansion program only.*

Response: For this reporting period, as part of the Medicaid screening process, children who applied to Nevada ✓ Check Up and appeared to be eligible for Medicaid were referred to the appropriate (by zip code) Nevada State Welfare District Office to make the Medicaid determination. Children who applied for Medicaid at the district office and were found ineligible or were terminated from Medicaid due to excess income or resources were referred to Nevada ✓ Check Up.

The health benefits package for Nevada ✓ Check Up is Medicaid's, and the same Medicaid providers (managed care and fee-for-service) are used. Health benefits are delivered by health maintenance organizations in northern and southern Nevada, and by fee-for-service providers in the rural areas. In addition, certain services are carved out of the health plan benefits packet, such as dental, hospice, non-emergency medical transportation, nursing home says over 45 days, Indian Health Services and Tribal Clinics, school-based services, hospice, and residential treatment centers are paid through FFS wraparound.

Because CHIP contracts with the Medicaid managed care health plans, the contract oversight of the health plans (health maintenance organizations) is done in conjunction with the Medicaid Managed Care staff. This includes utilization and financial reviews, and access to care. The fee-for-service providers are reimbursed at the Medicaid rate for services rendered to an eligible CHIP child. The Medicaid fiscal agent, Blue Cross Blue Shield of Nevada, has a contract with CHIP to reimburse the providers.

The Health Division's Maternal and Child Health staff has been trained on the eligibility process as well as given applications and marketing posters. Program staff will attend the Governor's Maternal and Child Health Advisory Board Meeting to provide an update on the Nevada ✓ Check Up Program.

The Division of Health Care Financing and Policy and Health Division entered into an inter-local agreement

for exchanging information between the two Divisions for children with special health care needs. The Health Division's Children With Special Health Care Needs (CSHCN) program will provide Nevada ✓ Check Up with names of children who are receiving services who might be eligible for Nevada ✓ Check Up. The agreement also includes the two Divisions referral process between the 37 statewide Women, Infants and Children (WIC) sites and Nevada ✓ Check Up, because families who qualify for WIC may be eligible for Nevada ✓ Check Up. This collaborative effort between the two Divisions provides Nevada families with the information they need to obtain low-cost health insurance for their children.

An inter-local agreement was done between the Division of Health Care Financing and Policy and the Department of Education to market Nevada ✓ Check Up through the School Lunch Program through the 17 school districts. This process was implemented in the summer of 1999 for the 1999-2000 school year resulting in over 14,000 households requesting a Nevada ✓ Check Up application.

3.6 How do you avoid crowd-out of private insurance?

Response: The child must be uninsured for 6 months prior to date of application.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Response: The eligibility determination process is as follows:

✓ Waiting period without health insurance (specify) – 6 months
__ Information on current or previous health insurance gathered on application (specify)
__ Information verified with employer (specify) – done during random audits
✓ Records match (specify) – fiscal agent will notify program
✓ Other (specify) - contracted HMOs required to notify program
✓ Other (specify) - Medicaid providers will inform program

Benefit package design:

___ Benefit limits (specify)
_✓ Cost-sharing (specify) – quarterly premium payment
___ Other (specify)
___ Other (specify)
___ Other policies intended to avoid crowd out (e.g., insurance reform):
___ Other (specify)
___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Response: The responses include (1) On Medicaid; (2) Covered Now : By_____; (3) No Coverage; and, (4) Date Ended_____ and Reason_____**:** The response to this question is entered into the program's application database.

For the period of October 1, 1998 through September 30, 1999, 295, or 4.86% of the children, were denied for having health insurance within the last 6 months of the application date. The following exceptions to the 6-month rule are as follows:

1. Loss of employment due to factors other than voluntary termination;
2. Death of a parent;
3. Change to a new employer that does not provide an option for dependent coverage;
4. Change of address so that no employee-sponsored coverage is available;
5. Discontinuation of health benefits to all employees by the applicant's employer;
6. Expiration of the coverage periods established by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA);
7. Self-employment;
8. Termination of health benefits due to a long-term disability;
9. Termination of dependent coverage due to an extreme economic hardship on the part of the employee; or
10. Substantial reduction in either lifetime medical benefits or benefit category available to an employee and dependents under an employer's health care plan.

Children who obtained health insurance while enrolled in Nevada ✓ Check Up are as follows: 241 or 4.86% children were disenrolled from the program because the family got new health insurance, and 405 or 6.67% who were provisionally enrolled were disenrolled because they became eligible for Medicaid.

During the redetermination process, 75 children or 5.5% were disenrolled for getting new (private) health insurance, and 29 children or 2.1% were disenrolled for getting Medicaid. The child is disenrolled the next administrative month following when their rights to appeal have been exhausted. (1)

(1) Note: These disenrollments did not occur until October 1, 1999 to December 1, 1999.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

Response: Children ages 0 through 18, whose families have income at or below 200 percent of federal poverty level, who are uninsured and ineligible for Medicaid. During the Medicaid screening process, if a family's income is found between 133% and 166% of federal poverty level for a child age 0 – 6 and between 100% to 133% for children 6 and older, and their resource/assets do not exceed the Medicaid limit, they are referred to Medicaid. (This formula is used because Medicaid has income disregards and Nevada ✓ Check Up does not.) The family is afforded the opportunity to enroll their children in Nevada ✓ Check Up until a full Medicaid determination is made. If the family fails to cooperate with Medicaid, the children are disenrolled from Nevada ✓ Check Up.

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and there characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

Response: Refer to Tables 4.1.1.A, 4.1.1.B, and 4.1.1.C..

Table 4.1.1. A

Nevada

SCHIP Data System: Summary of State-Reported Enrollment Information

Program	Federal Fiscal Year/ Quarter	Age indicator	Ever Enrolled	New Enrollees	Disenrollees	Member Months	Average Months of Enrollment	Unduplicated Ever Enrolled per year
			Line 1	Line 2	Line 3	Line 4	Line 5	Line 6
S-SCHIP								
	1998/Q1		0	0	0	0	-	0
	1998/Q2		0	0	0	0	-	0
	1998/Q3		0	0	0	0	-	0
	1998/Q4		0	0	0	0	-	0
	1999/Q1	all ages	2,850	2,850	18	6,955	2.44	0
	1999/Q2	all ages	4,436	1,654	118	11,466	2.58	0
	1999/Q3	all ages	6,067	1,751	192	16,343	2.69	0
	1999/Q4	all ages	7,190	1,335	248	20,025	2.79	7,573

Table 4.1.1.B

Nevada

S-SCHIP Enrollment Statistics FFY 1998 and FFY 1999

Table 4.1.1 in NASHP Framework for State Evaluations

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	0	7,573	-	7.2	-	91.7%
Age						
Under 1	0	203	-	5.8	-	89.2%
1-5	0	1,977	-	6.6	-	91.6%
6-12	0	3,429	-	7.6	-	91.8%
13-18	0	1,964	-	7.5	-	91.6%
Countable Income Level						
<=150% FPL	0	4,949	-	7.1	-	90.7%
>150<=175% FPL	0	1,566	-	7.5	-	92.6%
>175<=200% FPL	0	976	-	7.7	-	94.5%
>200% FPL	0	82	-	5.3	-	95.1%
Age and Income						
Under 1						
<=150% FPL	0	130	-	5.7	-	89.2%
>150<=175% FPL	0	48	-	5.5	-	87.5%
>175<=200% FPL	0	24	-	6.9	-	91.7%
>200% FPL	0	1	-	11.0	-	100.0%
1-5						
<=150% FPL	0	1,203	-	6.3	-	90.3%
>150<=175% FPL	0	449	-	6.7	-	92.2%
>175<=200% FPL	0	292	-	7.7	-	95.2%
>200% FPL	0	33	-	5.3	-	100.0%
6-12						

Table 4.1.1.B

Nevada

S-SCHIP Enrollment Statistics FFY 1998 and FFY 1999

Table 4.1.1 in NASHP Framework for State Evaluations

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
<=150% FPL	0	2,242	-	7.4	-	90.8%
>150<=175% FPL	0	707	-	7.9	-	93.1%
>175<=200% FPL	0	453	-	7.8	-	94.7%
>200% FPL	0	27	-	5.8	-	100.0%
13-18						
<=150% FPL	0	1,374	-	7.4	-	91.3%
>150<=175% FPL	0	362	-	7.9	-	92.8%
>175<=200% FPL	0	207	-	7.7	-	93.2%
>200% FPL	0	21	-	4.3	-	81.0%
Type of plan						
Fee-for-service	0	2,103	-	7.3	-	89.1%
Managed care	0	5,470	-	7.2	-	92.7%
PCCM	0	-	-	-	-	-

Table 4.1.1.C

Nevada

SCHIP Data System: Summary of Statistics Derived from State-Reported Enrollment Information

Program	Federal Fiscal Year/ Quarter	Age indicator	Ever Enrolled	Growth in Ever Enrolled over Previous Quarter[a]	New Enrollees	Disenrollees	Enrolled @ start of Qrtr[b]	Enrolled @ end of Qrtr[c]	Quarterly Growth rate[d]	Member Months	Average Months of Enrollment	Average Monthly Enrollment[e]	Quarterly Disenrollment Rate[f]	Unduplicated Ever Enrolled per year	Year-end Enrollees as a percent of Unduplicated Enrollees per Year[g]
C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13	C14	C15	C16
				(C4Q2 - C4Q1)/C4Q1			C4 - C6	C4 - C7	(C9 - C8)/ C8			C11/3	C7/C13		(C4 - C7)/C15
S-SCHIP															
	1998/Q1		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q2		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q3		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q4		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1999/Q1	All ages	2,850	-	2,850	18	0	2,832	0.0%	6,955	2.44	2,318.3	0.8%	0	-
	1999/Q2	All ages	4,436	55.6%	1,654	118	2,782	4,318	55.2%	11,466	2.58	3,822.0	3.1%	0	-
	1999/Q3	All ages	6,067	36.8%	1,751	192	4,316	5,875	36.1%	16,343	2.69	5,447.7	3.5%	0	-
	1999/Q4	All ages	7,190	18.5%	1,335	248	5,855	6,942	18.6%	20,025	2.79	6,675.0	3.7%	7,573	91.7%

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Response: For the period of October 1, 1998 through September 30, 1999, 6,074 children were denied enrollment. Of these, 1,226 children or 20.18% were denied enrollment because of access to or coverage by health insurance prior to enrollment. The information is obtained from the application; pulling up the Medicaid eligibility screen, and interfacing with the Medicaid mainframe enrollment file at the time of initial enrollment. The numbers and percentages are as follows:

Reason:	Number:	Percent:
Already enrolled in Medicaid	741	20.18%
Health insurance within 6 (1)	295	4.86%
Currently insured	190	3.14%
Totals:	**1,226**	**28.18%**

Note: (1) Considered covered by health insurance if insured within 6 months of date of application.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Response: In Nevada, the following public health programs are administered through the Department of Human Resources:

- Medicaid;
- Women, Infants and Children (WIC) program,;
- Children With Special Health Care Needs; and,
- Rural Clinics Community Outpatient Services.

The following public health providers provide health care services on a sliding fee scale or waive the fee:

- University of Nevada School of Medicine in Las Vegas and Reno;
- Federally qualified health centers (FQHC's) - Community Health Center of Southern Nevada (CHCSN)(1) in Las Vegas, and Health Access Washoe County (HAWC) in Reno;
- University Medical Center in Las Vegas – Outpatient Clinics;
- Saint Mary's Health Centers in Reno;
- County Health Departments; and,
- Washoe Medical Center in Reno – Outpatient Clinics.

The following private entities pay for medical services:

- Shriners
- Make A Wish Foundation; and,
- Medicine Program.

Public and private entities, such as Family Resource Centers, Family to Family, Baby Your Baby, and Covering Kids Coalition under Great Basin Primary Care (a public non-profit entity) refer children to public and private programs for services.

Note: (1) CHCSN lost it FQHC accrediation in March 2000.

4.2 Who disenrolled from your CHIP program and why?

Response: **7**33 children ages 0-18 were disenrolled from Nevada ✓Check Up for the following reasons:

Disenrollment Reason:	**Number:**
Child enrolls in Medicaid	342
Family does not apply for Medicaid	56
Child gets other creditable insurance	82
Child moves out of state	44
Child moves out of the home	9
Child becomes inmate of public institution +30 days	1
Child turns 19	12
Child gets married	2
Family does not pay premium	29
Failure to cooperate for other reasons	19
Loss of contact	89
Client requested disenrollment	9
Excess reported income	7
Other	31
Total:	733

In addition to the above, 446 children were disenrolled for being dually enrolled in both Medicaid and Nevada ✓ Check Up for the period of October 1, 1998 through May 30, 1999. This report was not compiled until after the October 1, 1998 through September 30, 1999, reporting period. These children were disenrolled within 60 days of discovery.

4.2.1. How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Response: For FFY 1999, a total of 733 or 9.7 percent of the 7,573 children disenrolled from Nevada' CHIP program. For the same period, Nevada's Medicaid's disenrollment rate was 16.8 percent (based on the FFY 1999 Quarterly HCFA 64EC reports). The CHIP disenrollment rate was lower than the projected disenrollment rate of 10 to 15 percent. The basis for this projection was the following: Nevada has a transitory population resulting in children moving in and out of the state; number of children who would be found eligible for Medicaid; and failure to pay the quarterly premium. The number of children who were disenrolled for the cited reasons were lower than projected, thus we had a lower than projected disenrollment rate.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not

re-enroll got other coverage when they left CHIP?

Response: The redetermination process began in July 1999; however, it was not completed until November 1999. The process included 5,675 children (3,080 families), of which 4,300 children or 75 percent were re-enrolled. A total of 1,375 children were disenrolled as follows:

Reason:	Quantity	Percent
- Did not respond to annual redetermination	503	36.6%
- Gross income too high	277	20.1%
- Did not return enrollment information	204	14.7%
- Lack of cooperation	153	11.1%
- Obtained new health insurance	75	5.5%
- Loss of contact	57	4.1%
- Moved out of Nevada	30	2.2%
- Complied and got Medicaid	29	2.2%
- Over program age limit	17	1.2%
- Child not in household	16	1.2%
- Voluntary withdrawal	7	5%
- Already enrolled in Medicaid	5	.4%
- Child deceased	1	.1%
- Parent became employed with the state	1	.1%
Total:	**1,375**	**100.0%**

The following 109 children who were disenrolled obtained other health insurance:

Reason:	Quantity	Percent
- Obtained new health insurance	75	68.8%
- Complied and got Medicaid	29	26.6%
- Already enrolled in Medicaid	5	4.6%
Total:	**109**	**100.0%**

4.2.3. What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Response: Whenever a member is disenrolled from the program, a numeric reason code is entered into the program's enrollment database. For the reporting period of October 1, 1998 through September 30, 1999, 733 children were disenrolled of the 7,573 children or 9.7%. The reasons for CHIP disenrollments are as follows:

Table 4.2.3*(1)*

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total

Total			733	9.7%		
Access to commercial insurance			82	11.2%		
Eligible for Medicaid			342	46.7%		
Income too high			7	1.0%		
Aged out of program			12	1.6%		
Moved/died			54	7.4%		
Nonpayment of premium			29	4.0%		
Incomplete documentation			19	2.6%		
Did not reply/unable to contact			89	12.1%		
Other-Lack of co-op with Medicaid			56	7.6%		
Other –Requests disenrollment			9	1.2%		
Other- Got married			2	0.3%		
Don't know			31	4.2%		
Other-Inmate of penal institute			1	0.1%		

(1) Source: Nevada ✓ Check Up Access enrollment database

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Response: Included in the Notice of Termination (Disenrollment) the family is informed that they have the right to appeal the decision, and that they can re-apply at anytime. In addition, those families that fail to submit the quarterly premium are given several reminders prior to disenrollment. If they fail to pay the premium the children get two months of free coverage. The notice also informs the family if they wish to re-enroll, they need to pay the back premium as well as the current premium unless it is a financial burden, then the delinquent premium will be waived.

Families who call in and request to voluntarily disenroll are encouraged by staff to reapply at any time their circumstances change.

In addition, children who are disenrolled because they are eligible for Medicaid and later are terminated from Medicaid because of excess income and/or resources, are eligible to re-apply for Nevada ✓ Check Up. In the Notice of Decision, the family is informed about Nevada ✓ Check Up, and encouraged to apply. A monthly report from the Welfare Division is sent to Nevada ✓ Check Up along with mailing labels. Upon receipt of the report, the family is sent a Nevada

✓ Check Up application.

4.3 How much did you spend on your CHIP program?

Response: Nevada ✓ Check did not begin providing health care coverage until October 1, 1998. During FFY 1999 a total of $2,080,863 was spent. Refer to Table 4.3.1.

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 N/A

FFY 1999 $5,642,294

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Response: Refer to Table 4.3.1..

Table 4.3.1 CHIP Program Type **State Stand Alone**				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		$5,642,294		$3,698,629
Premiums for private health insurance (net of cost-sharing offsets)*		$3,561,431		$2,314,930
Fee-for-service expenditures (subtotal)		$2,080,863		$1,383,699
Inpatient hospital services		53,650		34,623
Inpatient mental health facility services		21,200		13,781
Nursing care services		2,592		1,685
Physician and surgical services		193,552		125,809
Outpatient hospital services		312,799		203,319
Outpatient mental health facility services		35,229		22,899
Prescribed drugs		96,838		62,945
Dental services		1,236,331		803,615
Vision services		29,128		18,934
Other practitioners' services		21,879		14,220
Clinic services		28,586		18,581
Therapy and rehabilitation services		3,091		2,009
Laboratory and radiological services		3,476		2,259
Durable and disposable medical equipment		5,515		3,584
Family planning		0		0
Abortions		0		0
Screening services		66,048		42,931
Home health		356		231

Table 4.3.1 CHIP Program Type **State Stand Alone**				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Home and community-based services		0		0
Hospice		0		0
Medical transportation		6,010		3,908
Case management		320		209
Other services		12,548		8,157

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

Response: The total expenditures that applied to the 10 percent limit is $421,703. Refer to Table 4.3.2.

What types of activities were funded under the 10 percent cap?

Response: The 10 percent cap activities include the following administrative costs: personnel, contractors, training, computers, general supplies, leases, office equipment, copying, out-of-state traveling, utilities, and telephone). Also included are the marketing/outreach expenses which includes in-state travel and per diem, printing and mailing expenses.

What role did the 10 percent cap have in program design?

Response: In drafting the program's budget, the 10 percent cap played a major role in determining personnel/staffing levels, marketing and outreach activities, and whether or not to charge an enrollment fee and/or premiums. Determinations had to be made as to what positions were needed to design, implement, monitor and oversee the program. Once the positions were determined, a decision as to which positions would be state employees versus contract employees and when to hire.

To keep personnel costs at a minimum, rather than contracting out the marketing and outreach activities, a full-time marketing and outreach coordinator was hired to perform the following multiple roles: design the marketing/outreach materials and activities; assist in the design of the program's eligibility process; and supervise the eligibility staff (state and contract). Additional cost savings were realized by hiring two eligibility workers in September 1998 and July 1999, respectively, and supplementing with contract eligibility staff.

To keep contract costs to a minimum, the program decided to contract with the same Medicaid contractors as follows: fiscal agent, actuary, and peer review organization. This was possible because the program opted to provide the Medicaid benefit package which afforded the ability to contract with the Medicaid managed care contractors and fee-for-service providers. By so doing, this reduced the administrative costs related to recruiting new providers, as well as expending monies for oversight/monitoring costs. The program was able to contract with the following Medicaid contractors: fiscal, actuarial, and peer review organization. In addition, division contractors were used for information services.

Consideration was given to charging an enrollment fee to the family at the time of initial approval and a quarterly premium thereafter. The enrollment fee was seen an enrollment barrier; therefore, it was dropped and replaced with a quarterly premium. To assist the program with the 10 percent administrative cap, the premiums are applied to the program's administrative costs. As approved in the State Plan, 100 percent of the collected premium is used to offset administrative costs.

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share				**$421,703**		
Outreach				$126,589		
Administration				$295,114		
Other _____						
Federal share				**$274,107**		
Outreach				$ 82,283		
Administration				$191,824		
Other _____						

Note: Premium monies are used to offset administrative expenses but not outreach expenses.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

__✓ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
_✓ Other (specify) – Quarterly premiums

Response:

State Appropriations: The source of the state funds is from an account in the General Fund titled the Intergovernmental Transfer Account (IGT). The funds are received from the counties or local hospital districts. Local hospital districts are independent units of government with direct taxing authority, generally covering the same geographic boundaries as counties and run by an elected board. Counties and public hospitals pay IGT out of general revenues. All payments are made in full by the responsible entities; no money is withheld by the counties. The legislature has employed a methodology based on overall equity to all counties within the state in determining the amounts. (1)

1Response letter of June 17, 1998, to Richard Fenton, Deputy Director, HCFA, by Christopher Thompson, Administrator, DHCFP.

Quarterly Premiums: A total of $199,631.23 was collected in quarterly premiums for FFY 1999. The money is used to offset administrative costs and is not used as the state's match. The premiums are based on the family's gross annual income as follows: 100-150% of federal poverty level (FPL) $10; 151% to 175% of FPL - $25; and, 176% to 200% of FPL - $50. Premiums are waived for families under 100% of FPL.

4.4 How are you assuring CHIP enrollees have access to care?

Response: Assuring access to care under Nevada ✓ Check Up is as follows:

Access to care under a Managed Care Organization (MCO):

Under Nevada ✓ Check Up, approximately 75 percent of the enrollees access their care through a managed care organization. The role of managed care is to ensure accessibility/availability to appropriate health care, provide for continuity of care, and provide quality care to Nevada ✓ Check Up participants. A major focus of managed care is health promotion and disease prevention. The aforementioned populations, mainly comprised of women and children, will benefit from targeted preventive health care services. Preventive health services include prenatal care (including family planning services), access to primary care providers, and well-child care.

To assure CHIP enrollees access to care under managed care, the contracted managed care health plans are required to meet the following:

Member Handbook: Issue a new member a handbook within 5 working days of notice of enrollment.

Medical Card: Issue a new member his medical card within 10 calendar days of effective date of enrollment.

Primary Care Physician (PCP) or Primary Care Site (PCS): Each member must be assigned to a Primary Care Physician (PCP) or Primary Care Site (PCS) within 10 calendar days of the effective date of enrollment. The Contractor may auto-assign a PCP or PCS to a member who does not make a selection at the time of enrollment.

Travel to PCP: The Contractor must offer every member a PCP or PCS located within a

reasonable distance from the participant's place of residence.

Provider Network Access: The Contractor must establish and maintain provider networks in geographically accessible locations as specified in NRS 695C.070.11 and .080.2(a) for the populations to be served and in sufficient numbers to make available to participants all Contractor services in a timely manner in the service area. The Contractor's network must contain all of the provider types necessary to furnish the Contractor's health care benefits package.

The Contractor's provider network must contain all of the provider types necessary to provide to its members a continuum of services which include primary and preventive care, and includes the specialized care to handle complex health problems.

PCP-to-Participant Ratios: The Contractor must have at least one full-time equivalent (FTE) primary care physician for every 1,500 participants per geographic service area. However, if the PCP practices in conjunction with a mid-level practitioner (a Physician Assistant or an Advanced Practitioner of Nursing), the ratio is one FTE PCP for every 1,800 members per geographic service area.

PCP Network Requirements The Contractor must demonstrate the capacity of the PCP network meets the FTE requirements for accepting Nevada ✓ Check Up enrollees per geographic service area. This ratio cannot exceed the FTE requirement. In no case may a single provider accept more Nevada ✓ Check Up clients than allowed by the FTE requirement.

Primary Care Provider Participation: Per geographic service area at least 50% of all the Contractor's staff or contract PCPs must contractually agree to accept Nevada ✓ Check Up members. At least 50% of the aforementioned PCPs must accept Nevada ✓ Check Up clients at all times. If the Contractor has a contract with a Federally Qualified Health Center (FQHC) and/or the University of Nevada Medical School, the physicians of these two organizations can be counted to meet the 50% participation and 50% acceptance requirements.

Identification Cards: The Contractor must issue an identification card to the member with 10 calendar days of the effective date of enrollment that clearly states that the card does not constitute evidence of insurance coverage or Nevada ✓ Check Up eligibility. The card must include the following information: member's name and Nevada ✓ Check Up identification number; the Contractor's name and member services number; and, date of issue. The Contractor must educate its providers regarding the Nevada ✓ Check Up card issued to all members.

Primary Care Physician (PCPs) or Primary Care Sites (PCS's) Responsibilities: The PCP or a physician in a PCS must serve as the member's initial point of contact with the Contractor. As such, the PCP's or the physician at the PCS, responsibilities include the following:

1. Delivery of medically necessary primary care services and preventive services;
2. Provision of 24 hour, 7 days a week coverage;Referrals for specialty care and other medically necessary services covered in the health care benefits package;
3. Continuity and coordination of the participant's health care; and
4. Maintenance of a current medical record for the participant, including documentation of all services provided by the PCP and specialty or referral services or out of plan services such as family planning and emergency room services.

Although PCPs must be given responsibility for the above activities, the Contractor must agree to retain responsibility for monitoring PCP actions to ensure they comply with the Contractor's and the state's requirements.

The Contractor is prohibited from imposing restrictions for the above activities. The Contractor must agree to retain responsibility for monitoring PCP and PCS actions to ensure they comply with the Contractor's and the state's requirements.

Physician Specialists: Because of the large number of physician specialties that exist, the Contractor will not be required to maintain specific specialist to participant provider ratios for non-PCPs. The Contractor must provide access to all types of physician specialists for PCP referrals, and it must employ or contract with specialists in sufficient numbers to ensure specialty services are available in a timely manner. The minimum ratio for across the board specialists (those who are not PCPs) is one (1) specialist per 1,500 members per geographic service area (1:1,500).

These ratios may be adjusted for underserved areas, upon the analysis by state staff of physician specialist availability by specific geographic service area.

Complaint and Grievance: Children who are enrolled in a health plan are entitled to file a grievance, complaint and/or request a hearing. Since the Nevada ✓ Check Up contracted health plans are the contracted Medicaid Managed Care health plans, the same grievance, complaints and hearings policy is followed.

Grievances, Complaints & Hearings: The Contractor shall provide a procedure for internal resolution of participant's grievances and complaints within thirty days of receipt of the grievance or complaint. Contractor's procedure shall include involvement of a person(s) authorized to address and correct the grievance or complaint. The Contractor's internal policy and procedure must be reviewed and approved by the Division. The Contractor is encouraged to resolve participant grievances and complaints through this internal process. The Contractor's internal process is separate from the recipients' fair hearing rights for resolution of complaints.

Participant Grievance: The Contractor must have a process to resolve Nevada ✓ Check Up participants' grievances, which meets the requirements of Section 3105 (regarding grievances) of the DHCFP Administrative Manual. DHCFP will refer all participant grievances to the Contractor to be resolved. The Contractor is required to fully exhaust, in good faith, its internal resolution process on behalf of the participant before referring the participant to the DHCFP's hearing process.

Whenever the Contractor plans to deny a service, take an action, or fails to act on a claim for services with reasonable promptness, as defined in 42 CFR 431.201, the Contractor must meet all the requirements of 42 CFR 431 Subpart E and DHCFP hearing regulations, as specified in the Department of Human Resources, Division of Health Care Financing and Policy's Administrative Manual (DHCFP Administrative Manual), and NRS 695G.200 through 695G.230.

Access to Care Under Fee for Service:

New Member Brochure: Children who access their care under fee-for-service are mailed a brochure (English and Spanish) at the time of their Notice of Approval. The brochure explains what providers to use, how to receive services, what services are covered, no co-payments, and

who to contact for information.

Medical Card: A newly enrolled child will receive his lavender colored medical card from the state no later than the 10th day of his first month of enrollment, and every quarter thereafter. The card has the following information on the front: enrollee's name, billing number, and date of issuance. And, on the back is the following information: which services require a prior authorization and where the provider is to submit his claim.(1)

(1) Note: The program is considering redoing the medical card to look like the health plan's card which is a plastic card printed annually.

Providers: Approximately 27.5 percent of the children enrolled in Nevada ✓Check Up reside in the rural areas and access their care through fee-for-service Medicaid providers. Children who reside in remote areas of Nevada, that is, near the borders of other states, such as, California, Arizona, and Utah can access their care through providers in said states who are Nevada Medicaid providers.

The child's primary care physician can refer a child to a Nevada Medicaid specialist who is out-of-state when that type of specialist is unavailable in the state or is closer to the child's place of residence.

Emergency Care: An eligible child is covered for emergency services whether he is in state or out-of-state.

Prior Authorizations: To reduce the barriers to access to care, the only covered services that require prior authorizations are: orthodontic services, more than 7 steel crowns in one dental visit, and placement in a residential treatment center.

Complaint, Grievance and Hearing: Individuals who are disenrolled from the Nevada ✓ Check Up program have the right to be informed of their legal right to a case review if they believe the agency has taken/made an incorrect action. A written request for a case review must be received within 30 calendar days from the date of the Notice of Decision. The individual can submit additional documentation for inclusion in the case file at the time of the written request for review. For the period of October 1, 1998 to September 30, 1999, 33 households requested a case review of which 8, or 24.2%, were reversed because they submitted additional documentation showing them to be eligible.

The case review decision may be appealed by the client and a telephone hearing may be requested in writing within 30 calendar days from the date of the Notice of Decision. The agency will continue services if the recipient requests a case review in writing, within 10 days of receipt of the Notice of Decision. The recipient will remain enrolled until the appeal process has been exhausted; however, this does not apply to judicial review. The 25 households who were denied at the case review level did not appeal the case review decision.

The individual may at any time, within 30 days after the date the written decision is mailed, petition the district court of the judicial district in which the applicant resides to review the decision. The district court of the judicial district in which the individual resides will review the decision. The district court shall review the decision "on the record."

If a child is denied a medical benefit that requires a prior authorization, such as orthodontics, the recipient is sent a notice of denial. The recipient can request an administrative hearing within 30 days of receipt of the notice. The agency will continue services if the recipient requests the hearing within 10 days of receipt of the notice. For FFY1999, only one client filed for and had an administrative hearing for denial of orthodontic services not being medically necessary. The denial was upheld by the Hearing Officer.

Provider Education: Prior to October 1, 1998, Medicaid providers were mailed an informational letter informing them about the program. The letter explained the following: how they could become Nevada ✓ Check Up providers; Medicaid covered benefits package; services requiring prior authorizations; the issuance of the quarterly medical card; how to submit their billing claims; and the rate of reimbursement.

An annual provider education workshop was held in Reno, Nevada and Las Vegas, Nevada, over a period of several days. The workshop is co-sponsored by the Nevada Medicaid and Nevada ✓ Check Up along with the fiscal agent, Blue Cross Blue Shield of Nevada. To date, two such workshops have been held.

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Response: Refer to Table 4.4.1.

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits		MCO	
PCP/enrollee ratios		MCO	
Time/distance standards		MCO	
Urgent/routine care access standards		MCO	
Network capacity reviews (rural providers, safety net providers, specialty mix)		MCO	
Complaint/grievance/ Disenrollment reviews		MCO. FFS	
Case file reviews		MCO	
Beneficiary surveys		MCO, FFS	
Utilization analysis (emergency room use, preventive care use)		MCO, FFS	
Other (specify) _____			

Other (specify) _____			
Other (specify) _____			

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Response: The health plans are contractually required to submit utilization data to the program's actuary contractor. The following utilization data, along with the quarterly financial statements, is being reviewed by the actuarial contractor in determining the actuarially sound capitation rates for July 1, 2000:

ENCOUNTER

DHCFP requires continuous, rigorous monitoring of quality of care, access and utilization of services. Nevada will also evaluate its ability to control overall program costs through managed health care. Nevada uses encounter data submitted by the Contractor as one of its evaluation tools.

An encounter is defined as a patient contact for which, in the DHCFP fee-for-service delivery system, a claim could be filed.

Encounters

There are four types of encounters:

1. Ambulatory
2. Inpatient hospital
3. Drugs
4. Long Term Care (LTC)

Contractors contracting with Nevada provide a basic group of services and manage client health care in consideration of a monthly capitation payment for each client enrolled. The plan's medical practitioners submit claims or encounter data to the Contractor for services provided to clients. The Contractor is required to send specific data on encounters to DHCFP in accordance with specific media and file format requirements.

Encounter Claims

Encounter claims are submitted electronically only by the Contractor. Plans are required to submit encounter data at least once per calendar month. All encounter data must be submitted within 120 days of the date of service. If other insurance is involved, encounter data must be submitted within 365 days.

For more details, refer to the response in 5.1.7.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	__✓ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	__✓ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

4.4.3. What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Response: Nevada ✓ Check Up developed a bilingual member satisfaction survey that was released during the annual redetermination process. The survey was sent to 3,090 households of which 2,090, or 67.6%, responded. The respective questions and responses are as follows:

Question 11. If your child needed to be seen by a dentist, were you able to find a dentist who would treat him? Yes or No.

Response: Yes – 51.3%; No – 3.2%; No Response – 31.3%. About 70% of all respondents sampled said their children needed to see a dentist. About 80% of respondents in Clark County (southern Nevada) were able to find a dentist, while 70% in Washoe County (northern Nevada) and the rural counties were able to find a dentist.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

Response: A Request for Proposal (RFP) was released in late 1999 for an External Quality Review Organization, or peer review organization, to conduct an annual independent review of the contracted health plans beginning in the year 2000. The contract will be for six one-year contract years. During the six-year period, the EQRO will be responsible for monitoring and evaluating the contracted health plan in regards to access to care by Nevada ✓ Check Up participants.

The EQRO will be reviewing each of the contracted health plans in accordance with the following Quality Assurance Standards as stated in the managed care contract:

Pregnancy

Standard

The Contractor shall take affirmative steps to ensure pregnant Nevada ✓ Check Up participants are provided with quality prenatal care. Quality prenatal care provides for increased access to prenatal services, and ensures appropriate monitoring of high-risk pregnancies to obtain healthy birth outcomes.

Measurement & Methodology

The following HEDIS measures will be reported and baseline measurements will be established: (All HEDIS measures in this contract are to be reported for a calendar year, beginning in January of 2000 using the most current version of HEDIS. HEDIS measures may not necessarily correspond to the contract periods, but may overlap them).

"Cesarean Section Rate and Vaginal Birth After Cesarean Section Rate (VBAC rate)"
"Low Birth Weight Babies"

The C-Section threshold is 20%. A corrective action plan may be required if the annual rate of C-Sections for Nevada ✓ Check Up participants is above 20%. (Percentages will be based on the Contractor Reporting Guide, December 1, 1998, reported quarterly, on a year-to-date basis). Quarterly reporting provides for up to date measurement of the C-Section threshold.

Low birth weight (greater than or equal to 1500 gms but not greater than 2500 gms) will not exceed 7% of live births annually. A corrective action plan may be required if the Contractor low birth weight percentage exceeds 7% annually. (Percentages will be based on Contractor Reporting Guide, December 1, 1998, reported quarterly, on a year-to-date basis) Quarterly reporting provides for up-to-date measurement of the low birth weight threshold.

Stage of Pregnancy at Enrollment - A study will be conducted and reported quarterly, on a year-to-date basis to determine at what stage of pregnancy the teenager enrolls with the Contractor. The purpose of the study is to determine the percentage of teenagers who enroll with the Contractor late in their pregnancy. The Contractor will extrapolate participant delivery date data on an ongoing basis and compare it to Contractor enrollment data. A standard reporting format will be developed by DHCFP. The due date for the 1st, 2nd, and 3rd quarter reports is 45 days after quarter end. The due date for the 4th quarter and year-to-date information is 60 days after quarter end. Reporting began in January, 1999.

High Risk Pregnancies - The Contractor is responsible for the medical management of high-risk pregnancies.

A pregnancy is defined as "high risk" when there is a likelihood of an adverse outcome to the teenager and/or her baby that is greater than the incidence of that outcome in the general pregnant population.

A high-risk pregnancy report will be submitted to DHCFP quarterly by the Contractor. *Basic reporting requirements* include, but are not limited to, the following: Contractor name, Medicaid provider ID number, participant name, participant Nevada ✓ Check Up billing number, date of birth, and reason(s) for high risk. Contractor will provide management of pregnancy (e.g. case management involvement, including protocols, policies/procedures) and report outcomes of the pregnancies (status of both mother and child). A standard reporting format will be developed by DHCFP. The due date for the 1st , 2nd, and 3rd quarter reports is 45 days after quarter end. The due date for the 4th quarter is 60 days after quarter end. Reporting began in January, 1999.

DHCFP may conduct onsite reviews as needed to validate coordination and assess medical management of prenatal care and high-risk pregnancies.

Comprehensive Well-Child Periodic and Inter-periodic Health Assessments/Early Periodic Screening Diagnosis and Treatment (EPSDT)/Healthy Kids:

Standard

The Contractor shall take affirmative steps to increase participant utilization of the EPSDT program to a minimum participation rate of 80% of Nevada ✓ Check Up eligible children. Children who have been enrolled for twelve (12) continuous months must have an age appropriate periodic screening. Well-child care promotes healthy development and disease prevention, in addition to possible early discovery of disease and appropriate treatment.

Measurement & Methodology

The following HEDIS measures will be reported and baseline measurements will be established:

"Children's Access to Primary Care Providers"
"Well-Child Visits in the First 15 Months of life"
"Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life"
"Adolescent Well-Care Visits"

DHCFP Requirements:

Minimum: DHCFP will require that quarterly submission of progress reports outlining advances achieved in reaching the established EPSDT goals of the Contractor. The quarterly reports must address at a minimum these components: Program monitoring, Program evaluation, Member outreach, Provider education, and Provider compliance with mandatory components of EPSDT visits. The due date for the 1st, 2nd, and 3rd quarter reports is 45 days after quarter end. The due date for the 4th quarter is 60 days after quarter end. Reporting begins in January 1, 1999.

DHCFP may conduct desk and/or onsite review as needed, to include but not be limited to; policy/procedure for EPSDT, language in primary care provider contracts, process for notification of participants, Contractor internal quality assurance EPSDT monitoring, and outcome of referrals from EPSDT screenings.

If the Contractor has not achieved at least the 80% participation rate (based on the quarterly reports) for EPSDT services, the Contractor may be required to submit a corrective action plan to DHCFP. The corrective action plan should identify improvements/enhancements of existing outreach, education, and case management activities, which will assist the Contractor to improve the screening rate and increase the participation percentage.

Liquidated Damage: If indicated, liquidated damages will be calculated based on the initial annual review; that is, twelve (12) months of the contract year. Number of required periodic screenings not completed x periodic screening fee = liquidated damage.

Immunizations: The Contractor shall take affirmative steps to have 90% of Nevada ✓ Check Up eligible non-exempt children ages 0 through 2 appropriately immunized; 95% of Nevada ✓ Check Up children ages 3 through 18 immunized. A Nevada ✓ Check Up child must have been enrolled for 6 months before compliance with required percentages is calculated. Each immunization (vaccine) will be two encounter codes. One code will indicate administration of a specific vaccine by the Contractor; the second code will indicate a history of receiving a specific immunization.

The Contractor is responsible for implementing the most recent immunization schedule as endorsed by the Advisory Committee on Immunization Practices (ACIP) and the Nevada State Health Division.

Measurement & Methodology

Immunization status may be reviewed through EPSDT encounter data, EPSDT forms containing immunization documentation, and/or through an annual immunization audit based on DHCFP's or its designee's random sampling of EPSDT forms.

An action plan will be required from the Contractor if compliance is less than 90% for individuals ages 0 through 2, and/or less than 95% for individuals 3 through 18. The corrective action plan should identify improvements/enhancements of existing outreach, education, and case management activities.

Family Planning:

Standard

The Contractor shall take affirmative steps to ensure family planning services are provided to Nevada ✓ Check Up eligible participants (both male and female) of child bearing age. Child bearing age is defined as beginning at approximately10 years of age. Family planning services and education are an integral part of preventive health services for this Contract population.

A managed care participant has the right, by federal regulation, to receive family planning services from any qualified provider, even if the provider is not part of the Contractor's provider network. The Contractor may not require prior authorization of family planning services.

Measurement & Methodology

The Contractor will ensure age appropriate family planning services, including family planning education, are appropriately and adequately provided to 80% of eligible participants of child bearing age. DHCFP may review any or all of the following as needed, at least annually:

- Review of family planning expenses reported,
- Pharmacy, office visit, and EPSDT encounter data,
- Contractor policy/procedure related to family planning;
- Copies of health education and prevention materials communicated to participants, including a record of how such materials are communicated,

- Provider contracts to determine how family planning services/education are documented in Contractor provider subcontracts,
- Participant/guardian satisfaction surveys,
- DHCFP may conduct onsite review as needed to validate encounter data submission, and may verify service(s) were provided through participants whose records were analyzed during any review.

A sample of client records of participants who have been enrolled at least 6 months will be reviewed for compliance through annotation in the record that family planning information was offered or provided. An action plan will be required if the percent of compliance is less than 80%.

Appointment Standards:

Standard:

90% of appointments must meet time criteria (both for waiting and for number of days between request and appointment).

Measurement and Methodology:

Appointments with Primary Care Providers (PCP):

- Same day primary care provider appointments (e.g., high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room service) are available the same day;
- Urgent care PCP appointments (e.g., persistent rash, recurring high grade temperature, nonspecific pain , fever) are available within two calendar days; and,
- Routine care PCP appointments (e.g., well child/baby exams, routine physical exams) are available within two weeks. This two-week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two weeks.

Specialty appointments:

For specialty referrals to physicians, therapist and other diagnostic and treatment health care providers the HMO shall provide:

- Same day appointments within twenty-four hours of referral;
- Urgent care appointments within three calendar days of referral; and
- Routine appointments.

For maternity care:

The Contractor shall provide initial prenatal care appointments for enrolled pregnant participants as follows:

- First trimester within seven calendar days of first request;
- Second trimester within seven calendar days of first request;
- Third trimester within three calendar days of first request; and
- High-risk pregnancies within three calendar days of identification of high risk to the HMO or maternity care provider, or immediately if an emergency exists.

Office Waiting Times:

The Contractor shall monitor and ensure that a participant's waiting time at the PCP or specialist office is not more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Providers can be delayed when they "work in" urgent cases, when a serious problem is found, or when the patient had an unknown need that requires more services or education than was described at the time the appointment was made.

Methodology: Medical records will be reviewed.

DHCFP will validate this annually by means of on-site observations, chart reviews, enrollee satisfaction surveys, review of grievances, and interviews with enrollees. An action plan will be required if the 90% Standard is not met.

Mental Health Standard:

Standard:

The Contractor shall take affirmative steps to ensure adequate, quality, mental health services are provided to participants. Mental health is an integral part of holistic health care. The measurement methodology below demonstrates elementary steps toward continuing review of the quality of mental health care.

Measurement and Methodology:

The following HEDIS measure will be reported and baseline measurements will be established:

"Mental Health Utilization – Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services."

Participants determined severely emotionally disturbed (SED) or seriously mentally ill (SMI) will remain enrolled with the Contractor. DHCFP may review quarterly reports from the Contractor, to ensure coordination and continuity of mental health care.

A report will be submitted by the Contractor, quarterly, on a year-to-date basis, containing the following information: Contractor name, Medicaid provider ID number, participant name, participant Nevada ✓ Check Up billing number, date of birth, gender, date of SED or SMI determination, mental health services provided (including CPT codes for services, and type and amount of case management services). The due date for the 1st , 2nd, and 3rd quarter reports is 45 days after quarter end. The due date for the 4th quarter and year-to-date information is 60 days after quarter end. The standard reporting format will be developed by DHCFP. The Division may conduct

onsite reviews of participant charts if indicated.

For the first year (probably July 1, 2000 to June 30, 2001) of the EQRO contract, the Contractor will be responsible for doing a random review of each contracted health plan's EPSDT (Well-child care) program in accordance with the Quality Assurance Standard as cited in 4.4.1. This review will determine 1) if the child was referred to a provider for follow-up treatment and was the visit completed; and, (2) were immunizations done in conjunction with EPSDT screening exam. The purpose of the review is to evaluate the quality of EPSDT screening exams; evaluate the quality of EPSDT encounter data submissions; and, evaluate the comprehensiveness of EPSDT services. (1)

Note: (1) The results of the EQRO review and member satisfaction survey will not be available until at least July 1, 2001.

4.5. How are you measuring the quality of care received by CHIP enrollees?

Response: Measurement of the quality of care received by CHIP enrollees under Nevada ✓Check Up is through the bilingual satisfaction survey, health plan reporting data, and from utilization/encounter data from managed care and fee-for-service providers.

Member Satisfaction Survey:

The following questions and responses pertain to quality of care:

Question 7: If your child is enrolled in a health plan (Clark County and Reno/Sparks residents please list the plan), how would you rate the overall quality of health care received? Very Good, Good, Fair, or Poor.

Response: Very Good – 54%; Good 40%; and, 6% did not respond.

Question 9: If your child is not enrolled in a health plan, are you satisfied with the health care services received? Yes or No.

Response: Yes – 36.7%; No – 3.3%, and 62% did not complete the answer.(1)

Note: (1) The next member satisfaction survey will be done by the EQRO contractor who will be responsible for contacting the households who did not return a completed survey and/or failed to answer one or more questions.

Managed Care Reporting Data:

The contracted health plans are required to submit quarterly member and provider complaint reports for the contract year. Of the three contracted health plans, only two have been contractors for a full contract year (October 1, 1998 through September 30, 1999). The results are as follows:

Health Plan of Nevada:

For the period of October 1, 1998 to September 30, 1999, none of the 1,107 members filed a complaint or grievance; and, 9 providers out of 300 filed complaints which were resolved in an average of 30 days.

NevadaCare Inc:

For the period of October 1, 1998 through September 30, 1999, NevadaCare Inc. had the following complaints:

During the 1st quarter (October – December 1998). 3 members out of 1,308 filed grievances and none of the 1,186 providers filed a complaint.

During the 2nd quarter (January – March 1999) 1 of the 1,971 members filed a grievance that was resolved in 1 day and none of the 1,186 providers filed a complaint.

During the 3rd quarter (April – June 1999) of the 2,527 members, 4 grievances were filed of which 2 were resolved in 1 day and 2 were resolved in 36 days; and, 1 provider out of 1,901 filed a complaint which was resolved in 38 days.

During the 4th quarter (July – September 1999) of the 3,350 members, 6 filed grievances of which 5 were resolved in an average of 13.2 days and 1 was resolved in 54 days. Four (4) providers out of 2,210 filed grievances which took a total of 36 days to resolve.

Amil International of Nevada:

For the period of January 1, 1999 through June 30, 1999, they had no member grievances or provider complaints.

United Healthcare:

For the period of May 1, 1999 through September 30, 1999, they are unable to provide any data regarding member grievances and provider complaints due to a programming problem with their management information system.

Managed Care and Fee-for-Service Utilization/Encounter Data

Under Section 7.1.2. of the State Plan, one of the quality of care measurements is Well Baby and Well-Child Periodic and Inter-periodic Health Assessment. The performance standard is 80 percent of the eligible children who have been enrolled for twelve months must have an age appropriate screening. The results are as follows:

Managed Care:

Health Plan of Nevada: Had 333 eligible children of whom 120 or 36.05% received a screening.

NevadaCare Inc: Had 620 eligible children of whom 203 or 32.7% received a screening.

Amil International of Nevada: Did not provide any data regarding screenings because they were a contractor with Nevada ✓ Check Up for only 6 months.

United Healthcare of Nevada: Did not provide any data regarding screenings because they became a contractor in May 1999; less than 12 months for the reporting period.

Results: As outlined in the managed care contract, neither Health Plan of Nevada nor NevadaCare Inc. met the quality of care standard. The contracted EQRO will be working with the health plans to assist them in meeting the standard.

Fee-for-Service:

For the period of October 1, 1998 through September 30, 1999, there were a total of 381 eligible children of which 139, or 36.0%, received a screening.

Note: Each child is only counted once even if he had more than one screening.

Results: In the program brochure that is mailed to each new family who accesses care under fee-for-service, information is provided about Healthy Kids Screening. Since 80 percent of the children under fee-for-service were not screened, the program needs to devise a better way to inform and educate the families about this service.

Under Section 7.1.2 of the State Plan, one of the quality of care measurements concerns dental services for children who were enrolled for one year. The performance standard is 20 percent of the children ages 3 to 5 are to receive at least one oral health cleaning and 50 percent of the children ages 5 to 18 receive at least one oral health cleaning. (1) The results are as follows:

Ages:	No.Children Eligible:	No.Children Screened	Percentage:
3 to 5:	94	47	54.0%
5-18	769	570	74.0%

(1) Note: Dental services are provided under fee-for-service, and each child is only counted once even if the child had more than one visit.

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Response: Refer to Table 4.5.1 below.

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)			
Client satisfaction surveys		MCO, FFS	
Complaint/grievance/ Disenrollment reviews		MCO,	

Sentinel event reviews			
Table 4.5.1			
Plan site visits			
Case file reviews			
Independent peer review			
HEDIS performance measurement		MCO	
Other performance measurement		MCO	
Other (specify) Utilization data _____			
Other (specify) _____			
Other (specify) _____			

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Response: The program sent a member satisfaction survey to families during the redetermination process. The survey was done for both fee-for-service children and children enrolled in a health plan. The respective survey question and response is as follows:

Question 10. If your child was seen by a doctor within the last 3 months, how would you rate the care your child received? Very Good, Good, Fair or Poor.

Response: Very Good – 45.1%; Good – 27.1%; Fair – 6.2%, and Poor 1.7%.

The health plans are responsible (per the contract) for submitting a copy of their grievance and complaint log on a quarterly basis. The results are summarized in 4.5. Whenever a Nevada ✓Check Up program staff takes a complaint from a family whose child is enrolled in a health plan, the staff person will inform the family to contact their health plan's Member Services. If the complaint is from a family whose child is covered under fee-for-service, a program staff member will try to resolve the complaint by contacting the provider's office.(1)

Note: (1) Beginning in July 2000, the External Quality Review Organization (EQRO) contractor will be reviewing the quality of care received by CHIP enrollees.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Response: As stated in the response to 4.4.4 and 4.5.2, future monitoring/evaluation will be done through a contracted External Quality Review Organization (EQRO), including a member satisfaction survey coordinated by the Nevada ✓ Check Up program. This data will be available approximately July 1, 2001.

4.5.4 Please attach any reports or other documents addressing access, quality, utilization,

costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Response: None.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

Response:

Nevada ✓ Check Up's application process is very simple. The application is one page, two-sided (bilingual) and only requires copies of the 2 most recent wage stubs for each working adult in the household or, if self-employed, a copy of the 2 most recently filed federal income tax returns. Because Nevada Medicaid's eligibility is based on adjusted income and resource/assets, a joint application was not developed. A total of 15,363 children applied to Nevada ✓ Check Up through September 30, 1999, of which 7,573, or 49.2%, children were enrolled.

To rate the Nevada ✓ Check Up application process, the member satisfaction survey had several questions regarding the program's application process. The overall response was favorable. The questions and responses are as follows:

Question 1. Please rate the application process when applying for the Nevada ✓ Check Up program. Very Satisfied, Satisfied, Dissatisfied, or No opinion.

Response: Overall, 90 percent of the respondents were either very satisfied or satisfied with the application process, except Washoe County in northern Nevada which was at 42 percent with approximately 2 percent dissatisfied.

Very Satisfied - 50.2%; Satisfied - 44.1%; Dissatisfied - 2%; No opinion - 1.7%; and, No answer - 1.9%.

Question 2. Was the application packet easy to read and understand? Yes or No.

Response: Overall, 95% of all respondents felt the application was easy to read and understand; 2.2% felt the application was not easy to read and understand; and, 1.8% did not respond.

Of the total 6,074 children who were denied through September 30, 1999, 1,472 children or 24.23 percent were denied for lack of co-operation of which approximately 60 percent were for failure to provide the required income documentation. In contrast, only 617 children or 10.16 percent were denied because their income was too high.

The Medicaid screening process is difficult to access because Nevada ✓ Check Up's eligibility is based on the family's gross annual income rather than adjusted income and resources, as is the case with Medicaid. The Nevada ✓ Check Up application does include a question regarding the family's resources/assets. If the family answers No (assets/resources do not exceed X amount), then the eligibility worker computes a percentage adjustment based on the age of the child and the family's gross annual income in determining whether or not to refer the family to Medicaid.

If a family appeared to be eligible for Medicaid, they were notified that they could provisionally enroll their children in Nevada ✓ Check Up, pending a Medicaid determination and that they would need to cooperate with Medicaid. This process resulted in only 405 children, who were provisionally enrolled, complied and were approved for Medicaid, thus disenrolled from Nevada ✓Check Up. However, a number of these children became dual eligibles resulting in the program needing to do financial and statistical adjustments on the respective quarterly HCFA 21 reports. Those who failed to cooperate with Medicaid were disenrolled from Nevada ✓ Check Up, resulting in the children not having any health insurance coverage. (1)

Under Nevada's State Plan, an annual redetermination process is required. The first one was done beginning in July 1999, which included 3,080 households, or 5,675 children who were enrolled anytime during the period of October 1, 1998 through June 30, 1999. The process for the family was simple; all they had to do was review the redetermination form generated from the families enrollment file in the data base, make any changes and sign and return in the stamped, self-addressed envelope, along with copies of their income verification.

The redetermination process was labor intensive and costly for staff. Each family received up to four written reminder letters and/or notices, depending on whether or not they responded. In addition, if the family responded and was approved, an enrollment packet was sent giving them 30 days to complete the enrollment form and submit their quarterly premium payment. The process took over 4 months to complete. However, 75% of the children who responded and were found eligible were re-enrolled, and another 5% who complied later were re-enrolled after losing one month of coverage.(2)

Note: (1) As a result of losing potentially eligible children due to failure to comply with Medicaid, the program has streamlined the referral process. Beginning in January 2000, rather than forwarding a copy of the Nevada ✓ Check Up application and copies of the income documents to the appropriate Nevada State Welfare District office, an eligibility worker from Nevada State Welfare will be onsite to make the Medicaid determination. The family will not have to have a face-to-face interview. The paperwork will be handled through the Nevada ✓ Check Up office. The worker will make the determination, enter it into the Welfare database and send the case file to the appropriate district office. If the child is approved for Medicaid and provisionally enrolled in Nevada ✓Check Up, the child will be disenrolled. This process will potentially reduce the number of dual eligibles as well as reduce the number of denials for lack of cooperation, thus affording the child health insurance through Medicaid or CHIP.

(2) On April 24, 2000, a State Plan Amendment was submitted to Health Care Financing Administration (HCFA) to change the annual redetermination process to a "rolling redetermination process" based on the child's most recent date of enrollment. This will afford the child up to 12 months of eligibility unless (not all inclusive) he turns 19, the state becomes his custodian, he is incarcerated in a penal institution for more than 30 days, receives SSI, becomes eligible for Medicaid, gets other health insurance, leaves the home, or the family moves to another state.

The program is considering ways to streamline the redetermination process. Passive redeterminations might be something the program will consider after we observe a pattern of redetermination behavior in our client families. This might include obtaining the non-self employed client families income verification from the state's

Employment Security Division rather than having the client submit copies of the two most recent pay stubs.

5.1.2 Outreach

Response: Our outreach efforts between October 1, 1998 through September 30, 1999 produced mixed results. The following is a summary of those activities categorizing them in terms of "successful" and "unsuccessful." A successful activity increased awareness of the program and enrollment. An unsuccessful activity generated little response. (See source chart and % of outcome listed below)

Successful:

Referral-based activities; media, friends/relatives and schools; and
Some partnerships within the state

Unsuccessful:

Wholesale distribution of applications
Meetings with limited exposure
Ability to maximize "sister agencies" assistance; and
Non-profit organizations

The following chart reflects the referral source and percentage of how an individual heard about the program. Outreach efforts during this period of time mainly have been focused on application distribution and presentations throughout the state.

Source	Percent
Media	10%
WIC	4%
Relative/Friend	15%
Health Department	3%
Baby-Your-Baby	1%
School	33%
Family to Family	2%
Family Resource Center	2%
Doctor	6%
Social Services	5%
Other	9%
Welfare Department	10%
Robert Wood Johnson	0%

Future marketing/outreach:

- Nevada ✓ Check Up has developed a new marketing/outreach strategic plan that is intended to accelerate the rate of enrollment of eligible children. This will be achieved by combining marketing events throughout the next year, with the implementation of a new and stronger partnership campaign. All marketing events and partnership campaigns incorporate a format that includes:
    - Target population;

- Intervention; and
- Expected outcomes

By designing all of our marketing and outreach in this format, we will be able to more effectively measure the success of our efforts and better access our outcomes.

5.1.3. Benefit Structure

Response:

Originally, the program was going to offer a health benefit package (Bronze VI) of the state's largest commercial health maintenance organization (HMO), and enroll all of the children in an HMO. Due to the limited number of HMOs in the state, and the fact that HMOs who were willing to contract with Nevada ✓ Check Up opted to provide services only in Washoe County (Reno/Sparks only) and/or Clark County. In order to provide health care services to children enrolled in CHIP, the state opted to offer the Medicaid benefits package.

By so doing, children residing in the rural areas can access their health care through Medicaid fee-for-service providers, and children residing in northern Nevada (Reno/Sparks only) and southern Nevada (Clark County) can access their health care through health maintenance organizations who are also contracted with Medicaid. Certain services are carved out of the HMO benefits package and provided under fee-for-service. These services include: dental, non-emergency transportation, nursing facility stays over 45 days, hospice, residential treatment centers, school-based services, and, all Indian Health Services and Tribal Clinics.

Under Nevada ✓ Check Up, dental services are provided under FFS, thus access to dental care is difficult because of the limited number of dental providers statewide who treat all of the Medicaid and/or CHIP children.(1)

Note: (1) In order to improve access to dental services, the program is considering including dental services in the health plans benefits package. This will require the contracted health plans to have contracted dental providers as part of their provider network. This has the potential of providing better access to dental services for children enrolled in Nevada ✓ Check Up.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

Response: Originally the program was going to have an enrollment fee, quarterly premiums and co-payments. When the program decided to offer the Medicaid benefit packet the program dropped the enrollment fee and co-payments; thus charging quarterly premiums only. A quarterly premium is charged per family (not per child) and is based on the family's gross income (federal poverty level) as follows: 100-150% FPL, 151-175% FPL, and 176-200% FPL. (Refer to chart below).

The premium is due at the time of initial enrollment. If the child initially enrolls in the third month of the quarter, the premium payment is applied to the next premium quarter. This affords the family free coverage for the child's first month of enrollment. Once enrolled, the premium is due on the first day of each quarter (January 1, April 1, July 1, and October 1).

Quarterly	Total Annual	Quarterly	Total

Family of 2	Quarterly Premiums	Annual Premiums	Family of 3	Quarterly Premiums	Annual Premiums
*Up to $16,950	$10	$ 40	*Up to $20,820	$10	$ 40
$16,591–19,355	$25	$100	$20,821 - 24,290	$25	$100
$19,356-22,120	$50	$200	$24,291-27,760	$50	$200

Family of 4	Quarterly Premiums	Total Annual Premiums	Family of 5	Quarterly Premiums	Total Annual Premiums
*Up to $25,050	$10	$ 40	*Up to $29,280	$10	$ 40
$25,051-29,225	$25	$100	$29,281-34,160	$25	$100
$29,226-33,400	$50	$200	$34,161-39,040	$50	$200

For FFY 1999 $199,631 in premium fees were collected. Of the 733 children who were disenrolled for the period of October 1, 1998 through September 30, 1999, 29 (or 3.9%) were disenrolled for failure to pay the quarterly premium. The family is given a 60-day grace period to pay the premium before their child is disenrolled. If the child wants to re-enroll, the family has to pay both the delinquent premium payment and the current premium payment.

Question 6. on the Member Satisfaction Survey asks the family about the amount of their quarterly premium and whether or not the amount is fair for the services received?

Response: Yes – 88.1%; No – 5.8% and No response – 6%. **Note:** The quarterly mean premium payment was $16.50.

Cost sharing (premium payment) is seen as a barrier for American Indians and Alaska Natives. As of September 30, 1999, 147 Native Americans were enrolled; the goal is to enroll 450 by October 1, 2000.(1)

To streamline the premium payment process, and to reduce the administrative cost of notifying families up to three times (30 days in advance of the premium due date; 10th day of the premium due month; and, 45 days into the quarter), consideration is being given to offering the family the option of paying the premium for a full year.

Note: (1) On April 24, 2000, a State Plan Amendment was submitted to HCFA to waive cost sharing (premium payment) for American Indians and Alaska Natives who are members of Federally recognized Tribes. As of June 1, 2000, 876 American Indians had applied of which 290 are enrolled.

5.1.5 Delivery System

Response: Originally the program was going to have all of the children enrolled in Nevada ✓ Check Up access their health care through a health maintenance organization (HMO). This was revised to only have those children residing in southern Nevada (Clark County) and northern Nevada (Washoe County - Reno/Sparks only) enroll in an HMO. The reason for the change was that none of the three contracted HMOs were licensed to provide services statewide, nor did any of the HMOs opt to provide services in the rural areas where they were licensed. As of September 30, 1999, 72.5% of the children enrolled in CHIP were accessing their health care services through HMOs.

Children who reside in the rural area (15 counties) access health care through Medicaid fee-for-service providers. As of September 30, 1999, 27.5% of the children enrolled in CHIP were

accessing their care through Fee-for-Service.

The delivery of services that are carved out of the health plans' benefits package are provided through a fee-for-service wraparound to all of the enrolled children. These services include: dental, non-emergency transportation, hospice, Indian Health Services and Tribal Clinics, residential treatment centers, school-based services, and nursing home stays over 45 days.

To improve the delivery of services, the program would like to contract with more health maintenance organizations, especially since there is only one in the north and none in the rural areas. The program would also like to have more contracted Medicaid providers in the rural areas to treat eligible Nevada ✓ Check Up children. During the next twelve months, additional provider workshops will be conducted to educate current and potential providers about the children's health insurance program (managed care and fee-for-service). (1)

Note: (1) The provider workshops have been scheduled as follows: June 14, 2000, Las Vegas, Nevada; June 20, 2000, Reno, Nevada; and, June 27, 2000, Elko, Nevada.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Response: The program requires the family to "self report" on the application whether or not they currently have or have had health insurance within 6 months of applying. Once enrolled, the family is required to inform the program within 30 days of receiving other health insurance. In addition, the program interfaces with the Medicaid eligibility screen to see whether or not a child has applied for Medicaid or is on Medicaid. However, if the family has not provided their Social Security Numbers, the match is more difficult; relying on the individual's name and date of birth (DOB). The results of the self-reporting and Medicaid match are as follows:

- 295 children were denied enrollment because they had health insurance within 6 months of application;
- 741 children were denied because they were on Medicaid;
- 241 children were terminated from the program because they got new health insurance; and,
- 405 children were disenrolled because they became eligible for Medicaid.

The family is again asked about other insurance during the redetermination process. Of the 5,675 children, 109 children or 1.9% were disenrolled for having other insurance as follows:

- 75 children reported that they had other insurance;
- 29 reported that they got Medicaid; and,
- 5 reported they were already enrolled in Medicaid.

The program's fiscal agent will inform the program whenever they discover a child has other health insurance in the course of reimbursing Medicaid providers. The contracted health plans are contractually required to inform the program whenever they discover that a child has other health insurance.

Nevada ✓ Check Up plans on performing random sample audits within the next year to verify with the applicant/head-of-household's employer the status of the employee's health insurance

coverage.

5.1.7 Evaluation and Monitoring (including data reporting)

Response:

Evaluation and monitoring of the contracted health plans during this reporting period was limited due to not having a contracted External Quality Review Organization (EQRO). To formalize the monitoring and evaluation of the health plans, the Division recently released a Request for Proposal (RFP) for a peer review organization (PRO) or External Quality Review Organization (EQRO) to do the following scope of work over a 6 year contract period:

- Perform a Consumer Assessment of Health Plans Survey (CAHPS);
- Review individual health plan EPSDT (Well-child care) programs;
- Document health plan compliance with the contractual "Standards of Internal Quality Assurance Programs"; and,
- Provide assistance to the Division in evaluation of HEDIS (Health Plan Employer and Data Information Set).

The health plans are also required to provide an annual independent financial audit report of their medical care and administrative costs for the contract/fiscal year. The health plans are required to submit encounter data and financial data to the program's actuary contractor. This information is used to establish actuarially sound rates. The actuary contractor is currently in the process of evaluating both sets of data.

The contracted health plans are required to report on a quarterly and annual basis to document performance and assure adequate program accountability. In the contract with the health plans they are required to provide a quarterly report on the number and types of grievances/complaints that they received, as well as the outcome and resolution time.

They are also required to provide the following encounter data on the following medically-related services: (1) outpatient/ambulatory services (physician visits, nursing visits, surgical services, anesthesia services, laboratory tests, radiology services, durable medical equipment (DME), outpatient hospital services, dialysis centers, etc.); (2) inpatient services (inpatient hospital services, nursing home services, long term care services; and, (3) pharmacy services. This information is currently being submitted to the actuarial contractor by the health plans in order for actuarially sound capitation rates to be established for the next contract period.

Encounter data is submitted for all covered services for which the HMO has incurred a financial liability, as well as approved claims and adjustments for covered services, which did not result in an HMO payment. This data is currently being reviewed by the actuarial contractor in conjunction with rate setting.

The health plans are contractually required to report encounter data regarding the following quality assurance standards:

- Comprehensive Well Baby and Well-Child Periodic and Inter-periodic Health Assessment –

Periodic screening;

- Childhood immunizations;
- Family planning services for members of child bearing age;
- Pregnancies; and,
- High risk pregnancies

Based on a trial reporting period of three months, the encounter data submitted to the actuarial contractor from the health plans was found to be incomplete. The actuarial contractor is working with the health plans to secure the necessary data along with the financial reports in order to devise actuarially sound capitation rates as of July 1, 2000.

The quarterly member/provider complaint and grievance reports submitted provided a limited amount of information. The available information is cited in Section 4.5. of this report.

The health plans are contractually required to collect and submit to the Division a statistically valid uniform data set measuring participant satisfaction prior to the third quarter of each contract year, unless the requirement is waived by the Division due to an External Quality Review Organization (EQRO) performed survey. Because the program needed the information prior to the third contract quarter, the Division did its own member satisfaction survey during the annual redetermination process which began in July 1999.

The next annual member satisfaction survey will either be conducted by the Division or in conjunction with the health plans. The External Quality Review Organization (EQRO) contractor will do the member satisfaction survey during the second or third year of its contract. The EQRO will compile and analyze the data, and if there is a valid area of concern the health plan will be required to produce a corrective action plan.

Encounter data is also obtained from the program's fiscal agent on those services that are carved out of the health plan benefits package, such as dental, residential treatment centers, hospice, nursing stays over 45 days, non-emergency transportation, school based services.. This data can be downloaded and analyzed for utilization rates and/or access to care, and for reimbursement rate analysis.

5.1.8 Other (specify)

Response: None.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Response: Nevada ✓ Check Up is trying to increase the number of children enrolled in Medicaid and CHIP; thus providing health insurance to more children. In order to do so, it is in the process of evaluating its marketing and outreach activities to determine why various populations as a whole or in certain geographic areas either did not apply or minimally applied. The evaluation will also include an assessment of the marketing and outreach efforts that have worked versus those that did not work and why. In addition, new and/or revised marketing and outreach activities are being formulated for consideration. Once a new marketing and outreach strategy plan has been implemented, the expected outcome is to have more children apply who are found to be eligible and enroll in Nevada ✓ Check Up or Medicaid.

The program recently revised its Medicaid screening process for those children who appear to be eligible for Medicaid. The process reduces various application barriers for the client in order to assure a full Medicaid determination. The goal is to approve more children rather than to deny them for technical reasons such as, lack of co-operation. In addition, the program revised its process of contacting those families whose children were denied Medicaid for excess income and/or resources as well as those children who were terminated or denied for disability under Supplemental Security Income (SSI). The goal is to get these families to apply for Nevada ✓ Check Up in a timely fashion so that their children can be enrolled. The program is also reassessing the process of trying to enroll the children who have been terminated from Medicaid due to excess income and/or resources to be enrolled in Nevada ✓ Check Up without a break in their health care coverage.

More medical providers are needed, mainly in northern Nevada and the rural areas. The program initially wanted to provide health care through contracted health plans statewide. This option was not feasible because the three contracted health plans were only able and/or opted to provide services in one or two geographic service areas. The program would like to have more health plan penetration in the state by either contracting with more licensed health plans or encouraging the contracted health plans to expand their geographic service areas.

Based on the results of the Member Satisfaction Survey, access to dental care is one of the major complaints even though about 80% of respondents in Clark County (southern Nevada) were able to find a dentist, while 70% in Washoe County (northern Nevada) and the rural counties were able to find a dentist. Like Medicaid, the problem is due to lack of providers willing to treat the children covered under Nevada ✓ Check Up. The provider is reimbursed at the Medicaid rate; however, unlike Medicaid, the provider needs a prior authorization only for more than seven steel crowns and orthodontic services. Nevada ✓ Check Up is in the process of informing the current and potential Medicaid dental providers through written communication and provider workshops about the program's streamlined reimbursement process. Consideration is also being given to including dental services in the health plan benefit package.

Nevada ✓ Check Up and Medicaid is partnering with the Northern Nevada Dental Association to get more dentists (including orthodontists) to provide dental services to the children covered under CHIP or Medicaid. Access to dental care in northern Nevada has improved because the federally qualified health center in Reno, Nevada, has hired a full-time dentist. The dentist and the three to four contracted dental hygienists provide dental services to children covered under Medicaid and

Nevada ✓ Check Up.

A dental residency program is established in the south and north. Also, a dental school is under development. The dental school will be able to provide Medicaid and Nevada Check Up children with dental services through a network of adjunct faculty located throughout Clark County (southern Nevada). As a Medicaid provider they are providing services to children covered under Medicaid and Nevada ✓ Check Up. The school is in the process of trying to recruit more dental residents to provide dental services, and eventually intend to provide services statewide.

5.3. What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Response: States should be afforded the flexibility to design and implement a CHIP program that reduces the number of uninsured families, thus reducing the overall rate of uninsured Americans. To increase the number of insured Americans, Nevada has the following recommendations:

Recommendation: Afford the state the flexibility of drawing more federal monies for marketing and outreach activities. Such as, increase the administrative cap from 10 percent to 15 percent; remove outreach and marketing from the 10 percent administrative cap; or, allow the state to draw up to 10 percent of its unused federal match for the FFY.

Reason: Under Title XXI, the marketing and outreach activities are part of the state's 10 percent administrative cap which is based on the amount of health care expenses the state has expended. Allowing a more market driven approach, the state can be more creative in its marketing and outreach activities in being able to reach the target populations. The more liberal approach will increase the enrollment of children in CHIP and Medicaid through out the nation.

Recommendation: Allow a state to expand their CHIP program to cover the uninsured parents of children enrolled in CHIP.

Reason: Children are more likely to receive health care when the entire family has access to coverage. A number of low income working adults cannot afford to pay for health insurance offered by their employer. Providing health insurance for the entire family under CHIP will reduce the overall rate of uninsured Americans.

Recommendation: Allow a state with a stand-alone CHIP program the option to require the Social Security Number (SSN) from the applicant, other adults in the household and/or children.

Reason: Under Title XXI, a state with an expanded Medicaid CHIP program can require the family to supply their SSN; however, a state with a stand-alone CHIP program cannot. The SSN is a unique identifier for doing Medicaid matches, income-reporting verification, and for special audits. Nevada is in the process of considering an inter-local agreement with the Employment Security Division to develop a database match of the working adults in the applicant's household. Without the individual's SSN, the match cannot be done.

<u>Recommendation:</u> Do not include the cost of an External Quality Review Organization (EQRO) in the 10 percent limit for administrative procedures.

Reason: Medicaid expansion programs receive 75 percent FMAP, whereas a stand-alone receives 65 percent FMAP. The administrative cap is difficult for a state to adhere to, especially when the state's health care expenditures are minimal due to low enrollment and/or low reimbursement rates. Contracting with an EQRO is an integral part in determining whether or not recipients are receiving quality of care through their health plan.